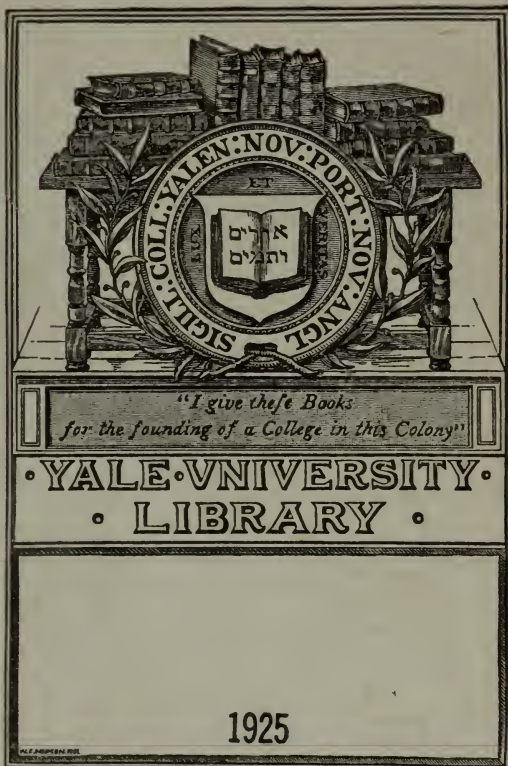


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THE INTRAVENOUS ADMINISTRATION OF SALVARSAN, APPARATUS AND TECHNIQUE.

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WITHOUT going into the comparative merits of the different methods of administering salvarsan, we think that this method of its preparation and administration is worthy of description. It is by no means original nor is there anything new claimed, simply the utilization of an ordinary piston syringe devised for this specific purpose which offers the advantage of simplicity, which in modern times is the aim of all operative procedures. It is a recognized fact that the intravenous method is *the method* of today, now since the technique has attained such a high degree of perfection. The advantages are many, namely: It is absolutely painless, during or after the injection; there are no infiltrations which may lead to bad after effects; since the system is saturated in a short time, the remedy has a more powerful toxic effect on the spirochaetes; the dose can be regulated with a greater degree of accuracy and reliability; the elimination being quicker, permits the administration of a second dose earlier than by any other method.

The technique, while not exactly simple, yet is by no means difficult. The apparatus consists of a graduated syringe, with metal plunger and slip-on joints. Syringes or joints fitted with leather or rubber washers will not permit of proper sterilization, the syringe soon becoming leaky and no longer air tight. A detachable two-way stop-cock, two pieces of rubber tubing about thirty centimeters in length, glass rod, pipette, one 250 cc. graduate, minim glass, and two medicine glasses. (Fig. 1.)

The ampule of salvarsan is placed in one of the medicine glasses previously filled with alcohol. Our technique is very similar to the directions on the literature accompanying each package. Forty cc. of sterile, filtered, physiological saline, made with distilled water, is measured in the graduate, to which is added slowly and with constant stirring the contents of one ampule of salvarsan. After solution has been entirely effected, and this is important because the final product being alkaline may contain insoluble flakes of salvarsan, nineteen minims of a 15 per cent. sodium hydrate solution is added, which causes a precipitate which redissolves by the addition of an excess of alkali. To insure sterilization, it is well to heat the alkali in a test tube. Enough of the physiological saline is added to the clear amber fluid to make 250 cc. The solution, which should show a distinctly alkaline reaction with litmus and be perfectly clear, is now ready for injection.

The stopcock is now connected to the syringe, and the rubber tubes to the stopcock. By introducing the tube ends into the medicine glass, which has previously been filled with saline, the syringe and the rubber tubes are filled with the latter, and so manipulated to expel all air.

Before the drug is administered a careful physical examination of the patient should be made. Enfeebled or prostrated individuals and others with affections of the central nervous system, heart, lungs, or those with pathological findings in their urine, if at all suitable for treatment, demand at least the exercise of caution. In secondary or tertiary lesions where ocular manifestations are suspected, we advise the examination of the eyes. A dark field examination is indicated in all primary lesions, and a Wassermann test in either primary, secondary, or tertiary stage. In secondary and tertiary stages we make a Wassermann test more to be informed as regards the extent of the infection, as well as to observe the curative effect which salvarsan may bring about. Individuals vary so greatly in physique, temperament, idiosyncrasies, etc., and the disease is so variable in character and pathology in the different stages, that experience alone along this particular line of work will familiarize the physician in planning, prognosing and executing curative treatment. The patient is instructed to refrain from eating for several hours before the injection. The usual surgical technique is now followed, such as washing the arm with soap and hot water, followed with a bichloride solution, then painted with tincture of iodine. After the iodine has remained for a few minutes, the area is finally sponged with alcohol. A rubber tourniquet is wrapped around the patient's arm above the elbow, and he is given a roller bandage to be firmly grasped. This latter assists in distending the veins. No rule can be fixed as to which vein to select, but any superficial vein which shows the best degree of distention and which seems easiest to the operator. Making sure that the syringe is in good working order, it and the rubber tubes filled with warm saline, the needle is now connected to one of the

rubber tubes and enough saline passed through it to expel all air. The needle is then thrust into one of the well-exposed and distended veins, and the tourniquet immediately removed. When the vein has been properly penetrated there is no swelling around the area of puncture while the saline is being injected, and the running fluid can be felt when the finger of the operator is held gently over the vein. If on the contrary there is swelling due to the saline passing into the subcutaneous tissues, the needle is withdrawn, the tourniquet again wrapped around the arm, and another vessel selected. When the needle is in the lumen of the vein and the saline flows slowly and properly, the rubber tube which is still in the glass containing saline is now transferred to the salvarsan container, the syringe and stopcock properly manipulated and the medicament



FIG. 1.

injected. The process is very simple, the one operator holds the needle very steadily, and this is very important, whereas the other manipulates the syringe. (Fig. 2.) After all the salvarsan has been injected or at least the required dose, saline is poured into the graduate, or the rubber tube transferred to the medicine glass containing saline, and the process completed with saline. This is to free the vessel from the salvarsan, a few drops of which may possibly leak into the tissues, causing pain and discomfort. The process is thus begun and ended with saline. Occasionally during the operation when everything seems to be working nicely, in spite of all care and attention there may be a sudden leakage of salvarsan into the tissues. This manifests itself by an immediate swelling at the site of puncture, and the patient at once complains of pain due to the irritating effect of the salvarsan in the subcutaneous tissues. In-

deed, the best indicator of telling if the fluid is running properly is the patient. Should there be an escape of fluid into the tissues, another vein must be selected as heretofore mentioned. The temperature of salvarsan when injected should be as near as possible to that of the body. This may be regulated by having all containers and the saline warm, and if necessary placing the graduate containing the salvarsan solution in a basin of warm water. A sharp needle adds much to the success of the procedure. We find the best way to keep the needles is to preserve them in liquid paraffin. It is well to keep several sizes on hand. In 153 injections thus far we have found it necessary only in one case to dissect out the vein, and this was the only one in which there was an infiltration or pain following the injection (one of our early cases). We thus



FIG. II.

look upon the dissection and exposure of the vein as entirely unnecessary except in the most exceptional cases, if for no other reason than the resulting exposed "tell tale" scar which must necessarily be objectionable and embarrassing to many patients. After the injection a collodion dressing is all that is necessary.

We find after the operation there is very rarely any reaction or ill effects of any kind until several hours have elapsed. This enables the patient to go home if he so desires but always with instructions to rest in bed for at least twelve hours; or better, having a special equipped room at our office we have the patient put at once to bed and remain until the nausea and rise in temperature passes off, usually in the course of six to eight hours. Thus where there is any objection to detention of any kind, it need not interfere with the administration of salvarsan.

1134 Linden avenue.

SOME FACTS THE GENERAL PRACTITIONER OUGHT TO KNOW ABOUT TONSILS AND TONSIL OPERATIONS.*

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THERE is no subject in which Laryngology and General Medicine come into closer relations than in that of "the Tonsils." Indeed, so intimate and so important are these relations that they have given us a new conception of many phases of internal medicine. Clinical experience has demonstrated that there is scarcely an organ in the body that, in consequence of tonsillar inflammation, may not become acutely or chronically diseased.

An enormous mass of literature in both special and general periodicals gives evidence of the appreciation and interest of the profession in this matter.

The *Surgical* aspects are no less important; Tonsillar Operations are the most frequent in the whole field of Laryngology; in fact they have come to constitute a considerable percentage of general surgical work, competing with the appendix for first honors.

Under these circumstances it has seemed to me that it might be profitable to pause and reflect upon these points:

1. Is the prevalent massacre of tonsils justifiable?
2. Is radical removal always necessary?
3. Should the general practitioner perform tonsil operations?

In discussing these questions I shall of necessity confine my remarks to the faucial tonsils.

Has the Tonsil any function and is it of any great value?

Upon embryologic and morphologic evidence, I am forced to believe that the tonsil is an essential part of the human organism and an integral part of the general lymphatic system, consequently that it has some function.

Notwithstanding a large amount of research work, the exact nature of this function is still uncertain; whatever this may be, it exists only during the developmental period, from birth up to 6 or 8 years.

With regard to the supposed "protective function" of the tonsils, the only one worthy of consideration, we must bear in mind these facts i.e.:

1. That this is exhibited only by *healthy* tonsils, in early childhood, during which period the tonsil attains its maximum development.
2. That it is slight, easily overcome, and no longer exerted by tonsils that have exhibited manifestations of disease.
3. That at most the tonsil is to be regarded as a part of the general lymphatic apparatus, and its removal of no more loss to the economy than that of any other lymph gland.

Clinically, we have abundant evidence that the removal of ton-

*Presented to the joint meeting of the Section on Clinical Medicine and Surgery and the Section on Laryngology and Rhinology of the Baltimore City Medical Society, December 1, 1911.

sils, *when diseased*, not only causes no injury, but is of the greatest benefit, both local and general, to the individual.

When is a tonsil to be regarded as diseased? We have no means of diagnosticating a "normal" tonsil; we are consequently driven back upon the clinical test; when a tonsil is productive of pathologic symptoms it is "diseased", otherwise it is normal.

Treatment is based not so much upon the size as the character of the glands: tonsils that are diseased and causing symptoms, no matter how *small* they may be, should be removed; whereas those producing no symptoms should not be removed, *even though hypertrophied*.

I am opposed to the indiscriminate removal of tonsils as practiced today. I am convinced that many tonsils are being removed unnecessarily by the inexperienced operator, both in adults and children.

The general practitioner should demand for himself as well as from others *definite* and *undoubted* indications for the operation. Tonsils that cause no disturbance need no treatment; mere hypertrophy in young children is not inevitably a sign of disease nor an indication for removal.

Nor should tonsillectomy be made the chance shot of the puzzled diagnostician.

In my belief the last word is still to be said regarding tonsils and tonsil operations.

There are two main *indications* for removal, to relieve:

1. Obstruction, due to large tonsils.
2. Absorption, through large or small tonsils, oftenest the latter.

Correspondingly there are two main *types* of *operation*:

Tonsillotomy, partial—mechanical symptoms.

Tonsillectomy—complete removal—absorptive symptoms.

The *method of operation* must be adapted to—

- a. The patient, in respect to age, temperament and constitution.
- b. The tonsil, as to size, consistence and relations.

Is radical removal always necessary?

In consideration of the uncertainty of the tonsillar function, and in view of its intimate connection with the general lymphatic apparatus; and not disregarding those rare cases of myxoedema that have been recorded as following tonsillar operations in young children; we should give all children under 8 years of age the benefit of the doubt, in the *absence of positive contra-indications* and perform *tonsillotomy* rather than tonsillectomy.

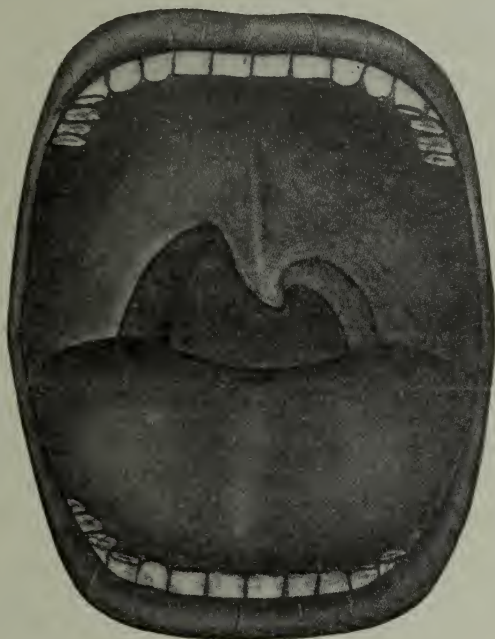
The soft tonsils of early childhood, projecting freely into the fauces and causing symptoms of *mechanical obstruction* only, can be rapidly and readily removed with the *tonsillotome*; what if they do recur, many regard this as an evidence of their usefulness to the child's organism, and if necessary they can be as readily removed again.

Other varieties of diseased tonsils, whether large or small, pro-

ductive of symptoms of *systemic infection*, must be radically removed by *Tonsillectomy*.

The object of this being the complete removal of all tonsillar lymphoid tissue, without or with the capsule, all methods that accomplish this object are to be regarded as efficient.

There are many satisfactory methods, each experienced operator having his method of choice, in which he is personally expert: I do not believe that there is any single method which must be adapted to every case. For my personal use, I prefer the method of sharp dissection in all difficult cases.



Deformity resulting from destruction of mucous membrane and muscular fibres connecting palatopharyngeus muscle to the middle of soft palate on right side, after amygdalotomy. (Dr. G. H. Makuen, *N. Y. Medical Journal*, Aug. 5, 1911.)

Methods of Tonsillectomy may be grossly classified as:

1. Punch—using pillar retractor.
2. Sharp dissection.
3. Blunt dissection.
4. Combination of dissection and snare.

Should the general practitioner remove tonsils? When and how? Dating from the invention of the tonsillotome, and based upon the facility with which this instrument can be used in the majority of cases, the tonsil operation has long been regarded as an easy one, to be performed by anyone. Unfortunately this impression is being transferred to present day methods, and many are now undertaking these radical operations with no adequate conception of their importance nor appreciation of their dangers.

The *truth about tonsils* is, that while some may be easy to remove, the majority are extremely difficult, requiring skilled surgical technique and the ability to cope with surgical emergencies.

The treatment of tonsils no longer belongs to the realm of medicine but of surgery, and no one without surgical instinct and surgical training should undertake these radical operations.

There are some tonsils which the general practitioner can remove thoroughly and safely, while there are other types whose removal is so difficult and attended with such danger that he had better let them alone. To be successful the practitioner must *discriminate* in the tonsils which he undertakes to remove.

The soft projecting tonsil, whether free or adherent, and even the medium-sized embedded tonsil, can usually be easily and efficiently removed by any one of moderate operative skill.

On the other hand, the large submerged tonsil, with prolongations extending high up into the body of the palate (velar type), or the tonsil whose capsule has become adherent to the surrounding tissues (arches and muscles) from repeated inflammation, is one both difficult of removal and attended with troublesome hemorrhage.

And yet it is just this type of tonsil that is the most frequent cause of systemic infection, and whose radical removal is imperatively indicated.

Until comparatively recently the complete removal of the diseased tonsil has been the sole test of a successful operation.

This is by no means always easy of attainment; in embedded tonsils with palatal prolongations, frequently a mass of tonsil is left in the supra tonsillar fossa, to reproduce all of the pathologic symptoms, or the velum and arches are seriously injured in the endeavor to remove the tonsillar apex.

Anyone who can remove this type of tonsil completely in a reasonable time, without undue loss of blood, and without damage to adjacent structures, deserves to be considered an *expert*, whether he be general practitioner, surgeon or specialist.

Another type which the general practitioner had best let alone, on account of danger of hemorrhage, is the fibroid tonsil of adolescence and adult age: (feel tonsil with finger) this is probably best removed by sharp extra-capsular dissection.

But modern surgery demands that not only shall the tonsils be removed *thoroughly*, but *safely*, and with as *little loss of blood* as possible.

In my observation and experience there is no *method* of operation that can be relied upon as a protection against hemorrhage; I have observed serious hemorrhage after the snare, the cautery and blunt dissection.

Tonsillectomy is then an operation in which hemorrhage is almost inevitable, and of a type requiring intervention.

The operator who is afraid of hemorrhage should not do ton-

sillectomy, as the only protection is his ability to cope with the same by usual surgical methods.

All spurting arteries, bleeding veins, or even muscular tissue, should be picked up with hemostats and ligated with catgut. In this way the tonsillar wound becomes dry, and I have frequently seen it glazed when the patient leaves the operating room.

Here let me call your attention to the deceptiveness of an "oozing" wound, which usually means an overlooked definite source of hemorrhage. To leave such a wound is careless and invites complications.

Even though loss of life may not occur, what right have we to subject the patient, generally a child, to anemia and prolonged ill health from preventable loss of blood?

When the primary hemostasis is thus carried out, there is little chance of secondary hemorrhage.

Should such occur, after removal of the blood clot, the bleeding point should be sought, best under general anesthesia, and ligated.

A further desideratum in tonsillar surgery is the *avoidance of unnecessary traumatism*. Forcible dragging and tearing of tissues results in excessive after-pain, slough and liability to sepsis. This is a frequent cause of marked prostration in young children. Tearing of the superior constrictor muscle not only provokes troublesome hemorrhage, but may cause local cellulitis, torticollis or abscess of the cervical or deeper lymph glands (angular or latero pharyngeal), or open up a direct avenue of systemic infection.

These complications are not to be regarded as being inherent in the operation, as the laity believes, but as unnecessary and avoidable.

For this reason I am opposed to forcible pulling and "ripping," dissection with absolutely blunt instruments (such as the finger, blunt elevators, button hook, etc.), and prefer sharp or semi-sharp instruments (knives, fine wire snare).

For the operator of moderate skill, I believe that traction on the tonsil with forceps, loosening up with sharp knives, and removal with the cold wire snare, constitutes an easy, rapid and efficient, if not the best, method of operation.

To be successful and *safe*, the practitioner should not only select his cases for operation, but should *refuse to operate* under conditions where emergencies cannot be met.

Tonsillotomy with the tonsillotome, in young children, is usually safe, even at the home; and yet with inadequate assistance, poor light and no provision for hemorrhage, the difficulties and risks even of this "simple operation" are far from negligible.

When to these are added the risks of general anesthesia, I do not know whether to pity the folly or admire the nerve of the man who is willing to assume such a handicap.

Another practice of which I frequently hear is that of turning

children out to play on the street within a few hours of a tonsil and adenoid operation.

Besides the very manifest risk of raising the blood pressure and causing a hemorrhage, we have that of sepsis and contagion.

The accidents which follow these practices, it seems to me with increasing frequency, damage not only the operator, but the entire profession.

Tonsillectomy, by whatever method, in older children and adults is regarded by the men of the widest experience as a hospital operation, on account of the attendant dangers.

Isn't it time for the family doctor to stop assuring his patients that tonsil operations are "simple and free from danger," when experience proves the contrary?



Showing the uvula snipped off, pillars wounded on right side and adherent on both sides, with fossae obliterated, after amygdalectomy. (Dr. Makuen, *ibid.*)

Anesthesia: In children up to 15 years of age and in many adults, these operations are best performed under *general anesthesia*.

Now, judging by statistics, the anesthetic of choice of the average practitioner, especially in children, seems to be *chloroform*.

It seems unfortunate that the pleasantest and most easily administered anesthetic should be the most dangerous, but reported cases of fatalities show that in these patients of the lymphatic temperament and in the cooler latitudes chloroform is an *especially deadly* anesthetic.

Recorded deaths show this to be especially true in our own city.

It is, however, but just to state that this does not seem to be true in our Southern States and in warmer climates.

In our climate and in these cases, *ether* is unquestionably the safest and best anesthetic.

The employment of the vapor method facilitates anesthesia and avoids much loss of time in the operation.

In adults and older children *local anesthesia* may be employed. I have used many anesthetic solutions of cocain, novocain, alypin, quinin and urea, etc.

I am convinced that the use of adrenalin predisposes to secondary hemorrhage, and have abandoned its use, as I prefer to encounter my hemorrhage during the operation, when I am equipped to meet it.

At the last meeting of the American Medical Association at St. Louis, B. D. Sheedy of New York reported four cases of death from collapse following the injection of cocain and adrenalin solutions, of proper strength, into the tonsils.

Although personally I have never had an alarming experience, I can no longer regard this as a safe procedure.

I should therefore substitute alypin or novocain for cocain, for purposes of injection.

The main reproach to the unskilled operator has hitherto been failure to completely remove the tonsils; today, unfortunately, we must charge to his account *serious injuries* to the structures and functions of the throat.

While we have paid undue attention to the more or less obscure functions of the tonsils, we have disregarded or lost sight of the definite and well established functions of the palatine arches, soft palate, tongue and pharynx in the processes of deglutition, speech, articulation, singing and audition.

In the anterior and posterior palatine arches run strands from the palato glossi and palato pharyngei muscles; these structures are intimately concerned in the finer movements of articulation and of singing, and through the pharyngo-salpingeal fibers, with the patency and ventilation of the Eustachian tubes.

The soft palate is one of the most important of the phonatory organs, and upon its normal action depend the resonance, quality and pitch of the voice.

The three important phonatory organs, the tongue, the palate and the larynx, are interdependent, and the larynx cannot act normally in voice production when the mobility of the tongue or the soft palate is impaired.

Even slight injuries and adhesions of the palatine arches may result in disturbed function, such as voice-tire in public speakers and singers, various perverted nervous sensations (paresthesias), etc.

More extensive injury may cause impaired speech and articulation (oral stuttering), destruction of singing voice, or when the

posterior arch becomes adherent, patulency of the tubal orifice from continued traction, and chronic tubo-tympanic catarrh.

Serious injury to the velum palati must result in impaired speech and deglutition (such as nasal intonation, regurgitation of food, etc.)

And yet the destruction of one or both palatine arches, the amputation of the uvula, or damage to the velum, does not seem to cause some operators any concern. I have seen the *pillars* hacked and mangled; I have known the anterior pillar to be split in half and the posterior torn from its roots by blunt dissection; I have known both the anterior and posterior pillars to be sliced off with a single sweep of the knife, to "get at" a buried tonsil, a true pharyngotomy.

So little is the importance of these structures appreciated, that a general surgeon in one of our hospitals is said to have proposed sewing the arches over the tonsillar wound, as a routine procedure, with the idea of preventing after-pain, hemorrhage and sepsis.

The *velum palati* has been cut and scarred; I have known it to be burst asunder in children, by the insertion of the finger or too large tampons into the epi-pharynx, or converted into a dense non-contractile membrane.

In view of the serious consequences of such injuries to the *voice* and the ease with which they may be produced, it seems to me extremely unwise for the general practitioner to undertake to operate upon the throats of public speakers and singers.

These cases should be entrusted to the specialist, who should operate with the greatest care and by sharp dissection; should injury to the arches or velum occur, he should endeavor to repair the same, as a part of the operation.

In conclusion permit me to reiterate that the ability to "get out the tonsil" is not "all that there is to the tonsil operation," but that modern requirements demand that this shall be attended with the least possible loss of blood, a minimum of after-pain and reaction, and avoidance of injury to important structures and functions of the throat.

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PROPHYLACTIC INOCULATION AGAINST TYPHOID FEVER IN INSTITUTIONAL AND PRIVATE LIFE.*

By F. W. Hachtel, M.D., and H. W. Stoner, M.D.

Baltimore, Md.

It is much to be regretted that of the larger cities of the country having a high typhoid morbidity, Baltimore stands among the first. While the general attack rate from this disease is high in our city, it is especially so among the nurses and attendants in our hospitals. Statistics recently collected from six Baltimore hospitals covering the past five years, while not entirely complete, show that the attack rate from typhoid fever among the attendants in these institutions is about 1.4 per cent. per year. In other words, the typhoid morbidity among the physicians, nurses and attendants in these six hospitals has averaged 140 per 10,000, as compared to 24 per 10,000, the general attack rate for the city for the same period of time. These figures indicate that the classes of people who find their vocation in hospitals stand about six times the danger of becoming infected with typhoid fever that the ordinary individual does.

With these facts in view, we were led to take up the subject of antityphoid vaccination by the report of Major Russell in the Johns Hopkins Hospital Bulletin for March, 1910. In this article the writer reviewed the results obtained by antityphoid vaccination in the British and German armies, and described his own methods of preparing and using the vaccine and the immediate results following 3600 inoculations.

Our first inoculations were made in March, 1910, at which time we injected volunteers from the laboratory force of the city and State boards of health, including ourselves. A short time later, through the kind efforts of Dr. Stokes of the Mercy Hospital, and Dr. Kintzing of the Franklin Square Hospital, we were enabled to immunize the resident staff and nurses of these two institutions. During the year of 1910 we administered the vaccine to 99 persons. This year, through the courtesy of various physicians, we have been able to introduce this prophylactic method into a number of hospitals in the city and State, and up to the present time over 1600 individuals have been inoculated with vaccines prepared by us.

We have been enabled to secure records of effects produced by the vaccines in 1579 cases. Seventy-one of these included laboratory force and medical students from the College of Physicians and Surgeons and the University of Maryland, whom we inoculated

*Read at the Annual Meeting of the Baltimore City Medical Society, December 5, 1911.

ourselves. Thirty-six others were private patients of numerous physicians, while the total number was distributed as follows:

Inmates of Springfield State Hospital, inoculated under the direction of Dr. J. Clement Clark.....	887
Inmates of Spring Grove Hospital, inoculated under the direction of Dr. J. Percy Wade.....	330
Staff and nurses, Mercy Hospital, inoculated under the direction of Dr. Eckhart.....	68
Staff and nurses, University Hospital, inoculated under direction of Dr. Howard J. Maldeis.....	88
Staff and nurses, St. Joseph's Hospital, inoculated under direction of Dr. Eugene Hayward.....	34
Staff and nurses, Franklin Square Hospital, inoculated under direction of Dr. Pierce Kintzing.....	16
Staff and nurses, Homeopathic Hospital, inoculated under direction of Dr. H. M. Stevenson.....	11
Staff and nurses, St. Agnes' Hospital, inoculated under direction of Dr. J. A. Chatard.....	38
Students, laboratory force, etc., inoculated by ourselves....	71
Private cases, inoculated by numerous physicians.....	36

Total..... 1579

Before proceeding with an analysis of the reports we have received from these institutions, we will briefly describe the preparation of the vaccines we employed. During the year of 1910 we made our vaccine from six strains of the typhoid bacillus, five of which were obtained from recent blood cultures. The sixth organism was one that had been in the laboratory for several years. A mixed culture of these organisms was made in bouillon and incubated for 24 hours, and this was inoculated on agar. Twenty-four-hour-old cultures were washed off with sterile salt solution and the organisms were killed by heating at 58° C. for 45 minutes. The vaccine was preserved in 0.25 per cent. tricresol. In 1911 our vaccine was made from a single strain of the typhoid bacillus furnished us through the courtesy of Major Russell, this being the same organism with which the army has been inoculated. The preparation of the vaccine was similar to that previously described, except that the organism was killed by adding 0.5 per cent. of carbolic acid. The vaccines were standardized either by Wright's method or by the modification of Wright's method first described by Harrison. Aerobic and anerobic cultures were made and a guinea pig and a mouse inoculated with portions of each stock of vaccine before it was distributed. At Springfield and Spring Grove hospitals tincture of iodine was applied at the site of injection just before and immediately following the inoculation. In our own cases the arm was simply rinsed off with 95 per cent. alcohol. Just what methods were used at the other hospitals has not been learned, but in every instance the scrubbing of the arm with soap and water and the application of an antiseptic was advised. In no case was needle

abscess or infection reported. The doses employed have varied somewhat. In our earlier cases we administered 125,000,000, 250,000,000 and 500,000,000, respectively. In 184 of our later cases, doses of 250,000,000, 500,000,000 and 1,000,000,000 were used.

Local tenderness and soreness were present in nearly every case. In 771, or nearly 49 per cent. of our cases, there was no general reaction; in 737, or over 46 per cent., the patients had a temperature between normal and 101° ; 42, or 2.6 per cent., had a temperature between 101° and 103° , and in 15, or 0.9 per cent., the temperature was 103° or over. Other reactions caused by the injections were general malaise in 733 cases; headache in 739 cases; muscular pains in 79 cases; nausea and vomiting in 38 cases; chills in 15 cases, and diarrhea in 6 cases.

Of the cases that had systemic symptoms, the latter disappeared in from 1 to 6 hours in seven cases. In 85 cases the symptoms persisted from 6 to 12 hours; in 89 cases they lasted from 12 to 24 hours; in 43 cases, from 24 to 48 hours; in 5 cases, from 40 to 72 hours; in 6 cases, from 72 to 96 hours; in 1 case for five days, and in two cases for over 10 days. In one of the latter cases, a female at the Springfield Hospital suffering from chronic mania, in whom a low grade of temperature persisted for two weeks, tuberculosis was suspected, and while no sputum could be obtained for the examination for the tubercle bacillus, the patient had a cough, with dullness over a portion of one lung, and also suffered from chronic constipation. In another institution two individuals in whose sputa the tubercle bacillus had been demonstrated were inoculated. One had a moderately severe reaction and the other only very slight reaction.

While it is too early to draw any conclusions as to the results of these inoculations in the prevention of typhoid fever, it may be mentioned that none of the individuals inoculated in 1910 or 1911 have developed the disease. It is interesting to note that one nurse from the University Hospital who was out of the city at the time the inoculations were made was attacked with typhoid fever. At St. Joseph's Hospital a nurse who was on her vacation at the time immunization was instituted developed typhoid fever. At the Franklin Square Hospital, where the nurses were inoculated in 1910, two out of eight nurses who subsequently entered the institution were stricken with typhoid fever. At Springfield Hospital 887 out of a total number of 1220 employees and patients were immunized. The attack rate from typhoid fever at this institution for the past five years has been about 1 per cent., or about 12 cases each year among the inmates of the hospital. During the past summer only three cases of typhoid fever developed in the institution, and these were among the 333 individuals who had not received the vaccine.

We believe that the vaccine is of undoubted value in the protection against typhoid fever, and, owing to the attack rate from this disease among hospital attendants, its use in this class is urgently recommended.

The use of the vaccine in institutions such as Springfield and Spring Grove is limited, in that at the present time our knowledge as to its action on individuals of advanced years, or individuals suffering from such chronic organic disturbances as cardiac lesions, arterio-sclerosis and albuminuria is so meagre as to prevent the use of the vaccine in this class of cases. However, the use of the vaccine in such institutions is desirable in preventing as far as possible both sporadic cases and epidemics.

The general use of the vaccine in private practice would undoubtedly produce a lowering of the morbidity from this disease. In order that its use may be popularized, the discomforts following the vaccinations must be as slight as possible. It would, therefore, seem that concerted efforts should be made to determine the minimum dose that will give the maximum protection. At the present time this seems a problem past solution. Just why one or two individuals receiving the vaccine under similar conditions should escape with only a slight soreness of the arm lasting but a few hours and the other have chills, vomiting, high temperature, etc., is unknown, although numerous theories have been advanced. These reactions of different individuals to the vaccine are not limited to the symptoms produced. Studies of the blood of a number of the cases we have inoculated have shown great variations in the amount of bacteriotropic substances formed. This is particularly noticeable in animals. We have studied the bacteriolysins, opsonins, and agglutinins in a number of rabbits inoculated with the vaccine, and found wide difference in the amount of these substances produced.

Of two rabbits of approximately the same size, inoculated at the same time with equal doses of vaccine, the blood of one was bacteriolytic at a dilution of 1-50,000; opsonic at a dilution of 1-1000, and agglutinated a strain of the typhoid bacillus at a dilution of 1-4000, while the second rabbit's blood was bacteriolytic at a dilution of only 1-250; opsonic at a dilution of 1-50, and agglutinated at a dilution of 1-1000. Of two other rabbits inoculated under similar conditions, the blood of one was bacteriolytic at a dilution of 1-100,000; opsonic at a dilution of 1-50, and agglutinated at a dilution of 1-50,000, while that of the second was bacteriolytic at a dilution of 1-500; opsonic at a dilution of 1-10, and agglutinated at a dilution of 1-2000.

It might be well to mention here that one rabbit was killed one week after having received three doses of 125,000,000, 250,000,000 and 500,000,000 dead typhoid organisms, respectively. Sections were made of the tongue, abdominal muscles, diaphragm, heart, lungs, liver, spleen, kidneys and bone marrow. Careful microscopic examination failed to reveal any fatty or parenchymatous changes in any of these tissues, and all the organs were apparently normal.

The problem of the reactions following the inoculations might be solved by inoculating the individual while young, the same as children are vaccinated against smallpox before they are allowed to enter school. Major Russell, in his article, "The Control of Ty-

phoid in the Army by Vaccination," in the *New York State Journal of Medicine* for December, 1910, states that the reactions following the inoculation of children are absent or very mild. The youngest of our series of cases was a child of four years, but we have been unable to secure any history as to the results following the inoculations. Here again we are confronted with the fact that we do not know just how long the immunity conferred by the injections will persist, as authorities do not agree on this subject, and if the antibodies disappear within three years or within five years, and if there is a progressive increase in the severity of the reactions as the individual grows older, by the time he reaches middle life he will have suffered as much from the discomforts following his numerous injections as is usually caused by a moderate attack of typhoid fever. We might add, however, that two of our cases were between 50 and 60 years of age, and suffered only moderate reactions.

While we are perplexed by these problems at the present time, it is to be hoped that their solution is not far off, and when they are solved we believe typhoid fever will become as rare a disease among civilians as it is today in our army, i. e., practically nil.

In conclusion, we wish to extend our sincere thanks to the physicians under whose care the inoculations were made for their kindness in allowing the use of the vaccines in their respective institutions, and for furnishing us with the records for the compilation of this preliminary report. We also wish to thank Dr. Stokes for the interest he has taken in this work and for the aid he has at all times generously extended to us.

DORLAND'S AMERICAN ILLUSTRATED MEDICAL DICTIONARY. New sixth edition, revised. Edited by W. A. Newman Dorland, M.D. Large octavo of 986 pages, with 323 illustrations, 119 in colors. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Flexible leather, \$4.50 net; thumb indexed, \$5 net. 1911.

The name Dorland is synonymous with the best in the dictionary line. Heretofore Dorland's dictionaries have always occupied a foremost position in their own field, and a careful inspection of the present edition amply warrants us in guaranteeing to our readers that the present revised edition will, as of yore, fulfil their every need. Dr. Dorland has a peculiar gift in building a dictionary suited to the needs of the medical profession, and has again produced a larger and better book than any of its predecessors. It is completeness personified, and contains not only terms employed in medicine and surgery, but also those used in the kindred professions (pharmacy, chemistry, veterinary medicine, nursing, biology and other sciences). The present edition contains 7000 more terms than the last and many new illustrations. Its usefulness is further increased by the inclusion of the pronunciation, derivation and definition of each word. As heretofore, Dorland's dictionary is more than an ordinary dictionary. It is, in fact, a medical encyclopedia which will be found by practitioner and student alike to completely meet their most exacting demands.

STATE DEPARTMENT OF HEALTH.

COUNCIL OF BUREAU CHIEFS.

November 29, 1911.

During the year 1911, the secretary of the State Department of Health has adopted the policy of holding councils with the bureau chiefs of the department, at least once monthly; special councils have also been held from time to time to consider various important questions requiring immediate action.

At the later meetings of the council the heads of the several bureaus have been instructed to present manuscripts, in order that permanent records could be preserved, and that the public should receive some information of the regular work which the department is carrying on.

The last of these councils was held on November 29, the secretary presiding.

Reporters.—Dr. Charles Caspari, State Food and Drug Commissioner; for the Bureau of Vital Statistics, Dr. Frederic V. Beitler, acting chief; for the Bureau of Chemistry, Dr. W. B. D. Penniman, chief; for the Bureau of Bacteriology, Dr. Wm. Royal Stokes, chief; for the Bureau of Communicable Diseases, Dr. C. W. G. Rohrer, acting chief.

Abolition of the Surface Toilet.—It is high time that health officers, hygienists and sanitarians arise in their might and declare that the surface toilet shall be abolished. The time is certainly ripe for such a step to be taken here in Maryland. During the 10 months of 1911 already passed there have been reported 1599 cases of typhoid fever, with 264 deaths. It is a reasonable estimate to say that 90 per cent. of these cases have arisen either directly or indirectly from pollution of private and public water supplies through the medium of that hydra-headed monster, the surface toilet. (Bur. Com. Dis.)

Abolition of the Public Drinking Cup.—That the public drinking cup should be abolished in Maryland was pretty clearly set forth in a statement presented at the regular monthly meeting of the State Board of Health, held on Thursday, August 3, 1911. The following infectious diseases have been known to be communicated through the agency of the public drinking cup: Tuberculosis, syphilis, typhoid fever, diphtheria, tonsillitis, Rigg's disease, influenza, meningitis, pneumonia, bronchitis, infantile paralysis, common colds and common sore throat. Such a step would not be a distinct innovation, because the public drinking cup was abolished in the State of Kansas on September 1, 1909. During the current year (1911), to my knowledge two more State boards—Oregon and Louisiana—have abolished the public drinking cup.

Abolition of the Common Roller Towel.—This problem is now before the Baltimore City Council and the solons of the Baltimore City Health Department. The campaign against these three unsanitary commodities—surface toilet, public drinking cup and com-

mon roller towel—should be educational rather than drastic. (Bur. Com. Dis.)

Some Unusual Causes of Death.—The certificates of death of Maryland for the month of September showed two deaths from caisson disease. These are the first deaths from caisson disease recorded in this State, both of them occurring near Cumberland, where they are doing extensive tunneling under a high air pressure. When individuals working in this high air pressure are rapidly brought to the surface and the high air pressure is relieved, it gives rise to a train of symptoms known as caisson disease. This is probably due to release of minute globules of air in the blood stream which reaches into the smaller vessels of the brain and prevent the proper passage of blood through them. This gives rise to an anemia in certain areas of the brain, which is usually followed by death. This condition can usually be prevented by carefully relieving the air pressure in chambers known as decompression chambers. These chambers are always found in well-conducted work. (Bur. V. S.)

State Board of Health Conducts Registration in St. Mary's County.—Having knowledge that the registration of births and deaths in St. Mary's county was very deficient, the State Department of Health, acting under Chapter 124, Article 43, Code of Public General Laws, deposed the registrar of vital statistics for that county and took charge of the collection of these statistics, with T. Spencer Crane as their representative. An enormous increase in the number of birth and death certificates over those of the corresponding year was immediately noticed. It is the intention of the State Department of Health to carry out these measures in all the counties in which registration falls below what is considered a normal number per thousand for that county. The accompanying figures are the birth and death returns for St. Mary's county during July, August and September, 1910, and the corresponding months in 1911. It will be seen by comparison that the increase amounts to, in some instances, over 300 or 400 per cent.:

<i>Year of 1910.</i>			
	July.	August.	September.
Births.....	2	0	4
Deaths.....	2	8	6

<i>Year of 1911.</i>			
	July.	August.	September.
Births.....	24	27	30
Deaths.....	22	15	22

(Bur. V. S.)

Anne Arundel County Midwives Practicing Unlawfully.—During the months of July and August the State Department of Health conducted an investigation of the midwives in Anne Arundel county, and found that out of a total of 119 midwives in this

county, 85 were not properly licensed and registered by the State Department of Health. All these midwives have had ample time (since July 1, 1910,) to present their qualification to the State Department of Health and receive a license and be properly registered if these qualifications permit. The existence of the midwifery law has been advertised from time to time, and no excuse will be taken from these midwives for such gross negligence. It is expected that individuals throughout the counties will request to see certificates of registration of all midwives before they employ them, as it is by this means only that they will know they are legally qualified to perform this important service. (Bur. V. S.)

Pellagra Causes Eight Deaths in Maryland This Year.—Since January, 1911, there have been eight deaths from pellagra in Maryland. This disease has been recognized as prevalent in some European countries, especially Italy, for a long period, but its existence in the United States was not generally known until a recent date. Since its recognition and description by a number of American physicians, patients having unusual intestinal symptoms, followed by a rash usually symmetrically distributed on the body, have been carefully observed for suspected pellagra. This disease is more prevalent in warm countries, but is not necessarily confined thereto. The exact cause is unknown. A number of observers seem inclined to think that it is closely associated with the use of corn, especially mouldy corn, as a food product. (Bur. V. S.)

CASE HISTORIES IN NEUROLOGY. By E. W. Taylor, A.M., M.D., Instructor in Neurology, Harvard Medical School; Assistant Physician, Department of Neurology, Massachusetts General Hospital; Visiting Neurologist, Long Island Hospital, Boston. Boston: W. M. Leonard. 1911.

"Case Histories in Neurology" embrace a selection of histories setting forth the diagnosis, treatment and post-mortem findings in nervous disease. This method of teaching students is becoming yearly more popular, and teachers in neurology who desire to test the diagnostic ability of their students will find the present volume an immense help. The cases are so selected that practically the entire field of neurology is covered. By this method it has been found that the essential points in diagnosis, symptomatology, treatment, diagnosis and post-mortem findings are better fixed in the mind of the student than by any other method of medical pedagogy. Such books as these are helpful not only to students, but also to the general doctor, as the arrangement of the cases is not haphazard, but, as for instance, in this case: (1) Peripheral, (2) spinal cord, (3) brain diseases, (4) those for which a definite anatomical basis has not been found, (5) the neuroses. Therefore, a practicing physician who has a patient with some obscure nerve affection of, say, the brain, could and will derive much benefit by reading the cases enumerated herein dealing with brain lesions.

INDUSTRIAL SCHOOL FOR THE CRIPPLED AND MAIMED AT CHARLEROI, BELGIUM.

By Douglas C. McMurtrie.

THE Industrial School for the crippled and maimed victims of work accidents was founded under public auspices at Charleroi, Belgium, in 1908. It was established through the efforts of a public-spirited lawyer, Paul Pastur. Although the victims of work accidents had, through Belgian legislation, been assured compensatory indemnity by the act of 1903, it had been possible to provide only incompletely for the consequences of serious mutilation.

In a report presented to the council of the Province of Hainaut, Messrs. Pastur and Caty set forth in no uncertain terms the necessity of and justification for the establishment of a training school for cripples.

An extract from this report reads as follows: "In what line of activity can the cripple employ what capacity is spared to him, when that capacity is reduced to 30, 40, 60, 80 per cent.? In industry, the factory and the shop have no place for him. The great industries and the small employers alike desire only capable and unhandicapped workers. Work which is becoming more and more mechanical demands of necessity able men endowed not only with intelligence but with vitality and dexterity. Of these last two qualities the cripple has but a small share.

"On the other hand, if the large manufacturer or the small employer enlists apprentices, they prefer young men because they learn more easily and rapidly. Furthermore, the crippled worker is exposed, especially during the early part of his apprenticeship, to the risk of additional accidents, and some liability companies forbid their employment, and regarding cripples employed industrially as hazardous risks they decline to issue insurance. The manufacturers are thus forced to the unfortunate necessity of refusing employment in their factories and shops to these unfortunates who have been crippled or maimed while working in their service.

"Finally it cannot be doubted that the apprenticeship to a new trade of a crippled worker whose efficiency is impaired 30, 40 or 50 per cent., and who is 25, 35, 40, 50 or 60 years of age, will take a period much longer than normal and the employer must take this into account when fixing his apprenticeship fee.

"In the last analysis, and the experience of other countries has demonstrated this beyond shadow of a doubt, it is necessary that the apprenticeship of these unfortunates shall be conducted in an informal and kindly manner. Patience and fraternal interest: these are the indispensable attributes with which those expecting to teach new trades to cripples must be endowed.

"Therefore, what is needed? An industrial school, where these workers can learn trades adapted to the limitations imposed by their strength, ability and degree of intelligence."

Following the recommendations of this report the council of the Province of Hainaut made an appropriation to aid in the establishment of an industrial school for cripples. This school was opened in 1908 and is under the direction of Dr. Dourlet.

The shops in actual operation are as follows:

1. The book bindery.
2. Shoe repairing shop.
3. Shop for the manufacture of grass carpet.
4. Basket making shop.

The school is made up of several sections:

1. The section for clerical employes, in which instruction is given in mathematics, bookkeeping, stenography, typewriting and manual work.

2. The section of apprentice tailors.
3. The section of apprentice saddle and harness makers.
4. The section of apprentice cobblers.
5. The section of apprentice bookbinders.

Under the rules of the institution all the crippled and maimed may take a course in the institution without regard to their mutilation or deformity. The pay of the apprentice pupils as well as of the workers in the shops begins one month after their admission. If they remain more than six months they receive pay for their first month as well.

The conditions of admission are:

1. To be crippled by accidents or congenitally deformed.
2. To be a Belgian and to have been resident in the Province of Hainaut for at least six months.
3. To be twelve years old for admission to the school and at least fourteen years of age for admission to the shops.

Pupils work under the direction of competent masters who show them how to execute the work and call attention to faults and errors. In the teaching system the pupils are merely shown the way of doing the work and the actual execution as related to their deformity or handicap, is left largely to their own ingenuity. It is hardly possible for the instructors to show a man with several fingers missing how to make a broom or repair a shoe. They can show them what needs to be done and the best way to do it and the cripple himself will have the best idea of his own capability.

Great ingenuity is shown in equipping some of the crippled workers for their specified trade. In some cases it almost seems as though they went to great extremes.

The general spirit of the institution and most of the pupils and workers seem to like their work. They are anxious to perfect themselves in their trades, and they have the highest regard for their instructors and the director of the institution. Little by little the establishment has developed a shop for making artificial ap-

pliances. Here are manufactured braces, splints and artificial limbs, which, although not as elegant as those made at the more extensive institutions, are still very useful, strong and practical. Furthermore, they are much less expensive.

In order to procure work to keep the shops busy the management conceived the idea of interesting the workers themselves in securing it. They established a commission of 5 per cent. to be paid to those who should procure orders for work. This system has had particularly favorable results in the shoe repairing shop. From all points in Belgium the workers receive from comrades or parents boots for repairs. They bring these to the institution. Thus the apprentices are interested in a pecuniary way in procuring their own means of instruction.

The workers live outside the institution. They come in the morning with their luncheon in a basket, and for a very small sum they are given dinner.

The institution at Charleroi is in many ways unique and it fills a need which must be felt in any industrial community. Victims of work accidents are generally in need through no fault of their own and the provision for their necessity by the state is an example which should be followed in other places.

A TEXTBOOK OF MEDICAL CHEMISTRY AND TOXICOLOGY. By James W. Holland, A.M., M.D., Professor of Medical Chemistry and Toxicology and Dean of Jefferson Medical College, Philadelphia. Third revised edition. Octavo of 655 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, \$3 net. 1911.

It would be extremely desirable that medical students should have finished their study of inorganic and organic chemistry before entering on their professional course, but such is not the case, and medical schools must provide a course of instruction in this all-important science. This places a great responsibility on the shoulders of the teachers of chemistry, as the time awarded them in which to complete their courses is entirely inadequate for a complete survey of the field, besides much of chemistry is not essential to medical needs. Holland's chemistry, as it omits the non-essentials and is written by a physician who knows what is essential and what unnecessary, will therefore be found an ideal textbook for students of medicine. The book contains a sufficiency of inorganic, organic and physiological chemistry to well ground the student in the essentials of chemistry. Unlike ordinary books on the subject, it points out and emphasizes the important rôle of chemistry in medicine. The chemistry of the proteids, urine, gastric contents, milk, blood, etc., is sufficiently full to equip the students with an accurate knowledge of the most approved methods of properly examining these substances. The additions and omissions in this edition have made it a better book than ever.

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BALTIMORE, JANUARY, 1912

HYGIENIC AND DIETETIC TREATMENT OF ARTERIAL HYPEREXTENSION.

THE dietetic and hygienic treatment of arterial hyperextension has been engrossing the best minds in the medical profession. It is now a well-established fact that by proper feeding and placing the patient under satisfactory hygienic surroundings the arterial pressure can be markedly reduced. Though a goodly number of dietitians recommend such reduction, there are just as many who frown upon the procedure. The latter reason that the effects of arterial hyperextension are mechanical, and compensatory adjustment soon alters the dynamics of the circulation to conform with the new status in the peripheral field. The tissues, as it were, become accustomed to a new standard of pressure with which we are unwarranted to interfere. Besides, as Arthur R. Elliott in the *Therapeutic Gazette* properly states, we do not as yet know what is the relation of arterial pressure to efficiency in the circulation, by which term is meant a certain rate and pressure of capillary flow essential to insure adequate metabolism and a complete return of blood to heart. Moreover, it is a well-established fact that in high arterial pressure a rapid fall indicates dissolution. We feel absolutely justified in maintaining that in chronic interstitial nephritis an arterial pressure of 200 mm. or higher is absolutely physiologic, and pernicious tampering with or reduction of the same under these circumstances is unjustifiable and prone to be complicated with cardiac embarrassment. We also subscribe to the opinion of Elliott that high blood pressure is not itself the cause of most of the symptoms attributed to it, these arising only when cardiac function becomes disturbed. The truth of this is adduced by undesirable symptoms following reduction in

blood pressure. Bearing the above statements in mind, one can readily observe that arterial pressure under any circumstance should be attempted only with the greatest of caution. Above all, do not overdo, but be satisfied with a moderate amount of reduction.

As patients suffering with high blood pressure must be under treatment over a long period, it is unwise to handle them too arbitrarily at the outset, as a sudden change of habits oftentimes does more harm than good. They should be subjected to a thorough physical examination, which should include all of the body secretions, especially the urine. In this respect the character and quantity of food ingested and the amount of nitrogen excreted should be carefully estimated. In other words, before instituting any line of treatment the elimination capacity of the kidney should be accurately determined; then the effect the raised pressure is having on the patient. If no untoward symptoms are being complained of, any severe method of lowering is to be sedulously avoided. Inveigle the patient by diplomacy to gradually assume the new routine of life. The immoderate use of tobacco should be interdicted, as tobacco undoubtedly aggravates the condition and is a powerful etiologic factor in its production. Emphasize the importance of using it temperately. Severe physical exercise should be vigorously proscribed. This does not mean that the patient is to cease all muscular effort, for it is essential to his well-being that he engage in mild exercise if he expects to maintain a normal body metabolism, as well as a satisfied mental equilibrium. If the physical condition of the patient is such that all exercise is unwise, a general massage to some extent will take its place. Warm baths are especially valuable.

As useful as are the hygienic rules briefly outlined above, they, however, play a minor rôle in the management of such cases. Diet is the important factor in restoring these individuals to a comparative state of well-being. The functional capacity of the kidney for eliminating nitrogen should be determined, and the protein diet regulated accordingly. The necessary amount of food to maintain health should be given mostly in the form of fats and carbohydrates. Both the liquid and solid constituents of the dietary should be reduced. This reduction is governed by the individual case. Though briefly outlined, this is the modern method of treating excessive pressure, and if practiced will be followed by gratifying results.

Medical Items.

DR. WARREN P. MORRILL, superintendent of the Sydenham Hospital, has tendered his resignation to Mayor Preston and will assume his new duties as head of the Winnipeg General Hospital, Winnipeg, Canada, during January. It is said that he will be succeeded at Sydenham by Dr. Robert A. Warner of 119 North Carey street.

DR. AND MRS. ARTHUR LOUIS FEHSENFELD, Garrison and Fairview avenues, Forest Park, Md., have announced the birth of a son in December.

DR. HARRY DORSEY PURDUM, chief resident physician at Bay View, has been appointed assistant physician and pathologist to the Springfield State Hospital, and will assume his new duties in about a month.

DR. ARTHUR DE T. VALK has been appointed resident physician to the James Lawrence Kernan Hospital for Crippled Children, and Dr. Walter S. Niblett, assistant resident. Dr. Harry W. Daniels will continue as head of the dispensary at 2000 North Charles street.

DR. HOWARD A. KELLY, who has been quite ill with typhoid fever at his sanatorium, 1418 Eutaw Place, is reported to be convalescing.

DR. BENJAMIN R. BENSON, JR., sustained severe bruises in an automobile collision at Marble Hill, Md., the evening of December 26.

DR. R. L. KEYSER has been named as coroner of the Eastern District to succeed the late Dr. Thomas Sudler.

THE condition of Dr. Charles H. Mayo of Rochester, Minn., who was twice operated on recently for appendicitis and gall-stones at the Presbyterian Hospital, is reported as being "eminently satisfactory."

DR. JAMES M. CRAIGHILL has removed his office and residence to The Walbert, Lafayette avenue and Charles street.

DR. EUGENE F. CORDELL, who has been confined to his home for some time, is now able to resume his professional duties.

MARRIAGES.

E. L. WILSON, M.D., Baltimore Medical College, '11, to Miss Brooksie McClelland at Alexandria, Va., May 31, 1911.

JOHN HENRY VON DREELE, M.D., University of Maryland, '10, of Baltimore, to Miss Marvel E. Scarff of Sharon, Md., at Baltimore, December 27, 1911.

FRANCIS P. O'NEILL, M.D., P. and S., '02, of Midland, Md., to Miss Elizabeth Barrett of Cumberland, at Cumberland, December 27, 1911.

NORMAN SPEAR DUDLEY, M.D., University of Maryland, '01, of Church Hill, Md., to Miss Clara Elizabeth Walls of Wilmington, Del., at Wilmington, December 21, 1911.

CHARLES MALLORY REMSEN, M.D., Johns Hopkins Medical School, '04, of Atlanta, Ga., to Miss Elizabeth Olive Patterson of Omaha, Neb., in New York, November 29, 1911.

RICHARD CALDWELL HUME, M.D., University of Maryland, '06, of Brookmeal, Va., to Miss Sarah White Cull of Baltimore, in December, 1911.

DON PRESTON PETERS, M.D., University of Virginia, '02, to Miss Retta A. Mencke, both of Baltimore, at Wilmington, Del., October 28, 1911.

DEATHS.

THOMAS C. PUGH, M.D., University of Pennsylvania, '59, died at his home, 2416 Madison avenue, Baltimore, December 27, 1911, of Bright's disease, aged 74 years.

ORVILLE LAYNE ROGERS, M.D., Vanderbilt University Medical Department, '81, died at his home in Covington, Va., December 26, 1911, aged 56 years.

GEORGE EDWARD GILPIN, M.D., University of Maryland, '82, died at his home in Berkeley Springs, W. Va., November 4, 1911, aged 65 years.

ANDREW DAVIDSON ESTILL, M.D., University of Virginia, '89, died at his home in Lexington, Va., December 25, 1911, aged 57 years.

SUMMERFIELD BERRY BOND, M.D., University of Maryland, '83, at his home in Baltimore, December 21, 1911, aged 51 years.

JOSEPH VANDEVANTER MILTON, M.D., University of Maryland, '01, at his home in Lacey Spring, Va., of pneumonia, aged 35 years.

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SHOCK.

By *Alexius McGlannan, M.D.*,
Baltimore, Md.

EXPERIMENTAL investigation made for the purpose of determining the pathology of shock has led to a number of different theories, all of which have been variously modified by the clinical study of this condition. Crile, Metzler, Seelig and Lyon, Howell, Porter and Henderson* have each shown by experimental investigations some phase of the nature of shock. The problem is not a new one, nor are the solutions proposed new. The theory of shock advocated by Keen, Mitchell and Morehouse (Circular 6, Surgeon-General's Office, 1864) is practically identical with that of Crile. While the results and conclusions of the different studies are contradictory as to the underlying basis of shock, it is possible that the differences are more apparent than real, and that it will be possible to reconcile them in further experiments.

Studied from the clinical point of view, most of the results and conclusions of the experimenters have been observed and corroborated, with the further conclusion that the basis of shock lies in several rather than in a single feature of pathological physiology. Fortunately, all of the conflicting theories seem to point to one method of treatment, and so the clinician need not be confused by the reports of the experimenters. Before considering shock as a clinical problem we shall review the more important experimental studies.

VASO-MOTOR EXHAUSTION THEORY.

Crile ("Keen's Surgery," Vol. I) and his associates, after many experiments, come to the conclusion that shock is due to exhaustion of the vaso-motor center. This exhaustion, they believe, is the wearing out of the center following over-stimulation. They show how the rise in blood pressure from moderate stimulation of a peripheral nerve passes into the low blood pressure of shock under repeated and more violent stimulation. They also conclude

*To avoid multiplication of references, only one publication will be cited for each authority whenever it is possible to give one that sums up the author's work and conclusions or gives full references to his other papers.

that the heart itself is not the cause of this fall in pressure, but that a general vascular relaxation following the exhaustion of the center is primarily responsible.

Going further into this subject, Crile and Dolley (*Annals of Surgery*, June, 1910) offer a proof for the anatomical basis of shock. They show certain marked changes in the Purkinje cells, which follow the production of experimental shock in animals. Going still further, Crile shows the production of identical changes in animals after great fear, violent physical exertion and other conditions which in human beings are followed by clinical signs of shock. Although some of Crile's theories are combated, and others require further experimental proof, great credit is due him for placing the study of shock on an experimental and accurate basis. In addition, we owe to Crile, more than to anyone else, credit for a logical and systematic therapy for shock.

Opposition to Crile's theory is made by Malcolm (*Lancet*, 1905, page 922), from the clinical study of shock, and by Seelig and Lyon (*Surgery, Gynecology and Obstetrics*, August, 1910, Vol. XI, page 146), from the experimental. These observers prove that in shock the peripheral vessels are contracted, a condition incompatible with vaso-motor exhaustion. Seelig and Lyon show by experiment that in shock the center is not only not exhausted, but in fact is more active than normal in response to stimulation.

CARDIAC THEORY.

Howell ("Bloodgood's Surgical Shock," *American Practice of Surgery*, Vol. I, page 467) describes cardiac shock in which the rapid, feeble heart beat and low pressure are due to strong inhibition leading to partial or complete loss of activity of the cardio-inhibitory center. He also recognizes a vascular shock in which low pressure is due to loss of activity of the vaso-constrictor center, but states, however, that the latter is always preceded or accompanied by the former, although the cardiac shock may occur independently. He further notes that the rate and amplitude of respiration are diminished in shock, and that stimulation of sensory nerve trunks leads to further fall in blood pressure, and to this extent augments shock.

INHIBITION THEORY.

Meltzer (*Archives of Internal Medicine*, July, 1908) offers the hypothesis that in shock the inhibitory side of the vital mechanism is over-active, leading to inhibition of the activity of the vaso-constrictor and the cardiac mechanism.

RESPIRATORY THEORY.

Henderson of Yale (*Johns Hopkins Hospital Bulletin*, Vol. XXI, page 235) brings forward experimental and clinical proof that the underlying cause of shock is insufficiency of the carbon dioxide content of the blood. The tension of this gas in the circulation is the normal stimulus of the respiratory center, and consequently is regulated automatically in a healthy individual under

normal conditions. If, however, the rate of respiration be markedly increased, the over-ventilation of the lungs causes an increased expiration of carbon dioxide and a corresponding increased inspiration of oxygen, resulting in a condition of over-oxygenation of the blood, with diminished carbon dioxide (acapnia). The respiratory center is thus robbed of its normal stimulus and spontaneous respiration ceases, although the heart continues to beat (apnea).

The sensitiveness of the respiratory center for carbon dioxide varies. If this sensitiveness is acute, and the acapnia is mild in degree, a vigorous circulation will permit vital processes to continue long enough for the accumulation of sufficient carbon dioxide in the blood to restore spontaneous respiration.

If, however, the acapnia is intense, apnea continues and death takes place in about eight minutes from oxygen starvation of the heart. When the quantity of blood is also diminished death occurs earlier, in about two minutes.

After the second minute of apnea the withdrawal of oxygen from the blood by the tissues causes an anoxemia. The condition may be a prophylactic one, in that the products of incomplete tissue combustion accumulate in the blood, producing an asphyxial acidosis, which aids in restoring spontaneous breathing, if acapnia is not too intense or the sensitiveness of the center is not too much blunted.

Cheyne-Stokes rhythm represents the effect on the respiratory act of anoxemia, tissue combustion and acapnia.

With the development of acapnia there comes dilatation of the splanchnic veins and a fall in blood pressure. The tonicity of the walls of the veins is in direct proportion to the carbon dioxide content of the blood. When this falls low enough there are complex osmotic changes in the tissues, with an exudation of fluid from the blood, dilation of the small veins and interference with the filling of the right side of the heart.

The great value of carbon dioxide as a vaso-motor stimulant, and, consequently, its effect on blood pressure, is shown by Sollman and Pitcher (*American Journal of Physiology*, June, 1910). They isolated the spleen from the circulation, but not from its vaso-motor connections, and perfused the organ with Locke's solution. Studying the rise in pressure under various stimulants, they found that this was three times as great in asphyxia as it was after sciatic stimulation.

Henderson points out that injury, fear, excitement, exertion—all factors in the production of shock—are associated with rapid respiration. He has produced all the symptoms of shock in an animal by over-ventilating its lungs. Furthermore, he quotes Crile and others to show that in their experimental work it was necessary to resort to artificial respiration in order to keep the animal living long enough to secure the evidence of the vaso-motor origin of shock. Therefore he concludes that the respiratory fail-

ure is the primary change in shock, and that the other phenomena are of secondary origin.

Henderson's proofs from clinical studies are very strong, especially in connection with the shock of operation under anesthesia and of the shock of anesthetics. (Gatch, *Journal American Medical Association*, Vol. LVII, page 1593.) By means of various devices for administering inhalations, it has been shown that one may control the rate of respiration, heart beat and blood pressure by proper administration of oxygen and carbon dioxide, especially by allowing the patient to rebreathe his own expired air. Henderson suggests the giving of a mixture of oxygen and carbon dioxide 20:1, by inhalation, for the treatment of shock. When respiration is seriously embarrassed, a small catheter may be passed to the bifurcation of the bronchus and a gentle stream of the mixed gases allowed to flow through it. As Meltzer and Auer have shown (*Journal of Experimental Medicine*, Vol. XI, p. 622), the diffusion of gases at this point is sufficiently active to carry the mixture to the pulmonary alveoli in the absence of any respiratory movement.

The work of Henderson shows how one vital process is directly dependent on another for stimulation to activity, and how a disturbance of one upsets the automatic mechanism of the entire system. From this point of view the interdependence may be likened to the influence of hormones in producing secretions.

To sum up and attempt a reconciliation of these divergent views of the underlying pathology, I offer the following definition: Shock is a condition of general depression due to inactivity of vital centers. The cause is well described by Gross as a rude unhinging of the machinery of life.

Clinically, shock is characterized by low blood pressure, shallow respiration, low surface temperature, muscular relaxation and diminished or suppressed secretion, with persistence of consciousness. It is extremely difficult to distinguish it from syncope and from the collapse of hemorrhage, so that we are still forced to Travers' opinion that "a fit of syncope and the recovery from it present an epitome of the phenomena of shock." ("Hoimes' Surgery," 1870, Vol. I, page 766.)

In shock the patient is quiet, but somewhat confused, the mental activity is slowed; the surface of the body is cold and the temperature is usually subnormal; reflexes are absent or diminished; the pulse may be either rapid or slow; the blood pressure is always low.

The relation of shock to hemorrhage is very close, and the influence of loss of blood on the production of shock is great and immediate. The differentiation of shock from concealed hemorrhage is very difficult, and occasionally impossible.

The pathological anatomy of fatal shock shows very little structural change or disturbance. The right heart and the veins, especially the splanchnic vessels, contain the blood. In some cases there is exudation of serum or water into the perivascular tissue. Crile's work on the etiology of shock has been mentioned.

TREATMENT.

In deliberate surgery our efforts are directed toward the prevention of shock rather than its cure. Proper anesthesia, the avoidance of rough handling of tissue, nerve blocking, when this is possible, control of hemorrhage, the protection of the patient from exposure and from wetting, careful preliminary preparation, are all factors in preventing shock. The control of fear, excitement and other psychic disturbances is an extremely important part of prophylaxis.

When shock has developed, the treatment is directed to removing the cause, if this is still active, and to restoring the balance of the vital mechanism.

Of all causes, pain, shown by the effect of peripheral irritation on the vital centers, is the most common and persistent. Hemorrhage, as a cause or complication, always requires consideration. Its control is by the usual methods. Anesthetics are important, probably acting through their benumbing influence on the respiratory center. Psychic causes are often active after all physical ones have been relieved.

For the relief of the causes of shock, other than hemorrhage and anesthesia, morphine in small doses is the best remedy.

To combat the low blood pressure and the other vascular phenomena, salt solution by the rectum, hypodermically or intravenously, should be used.

External heat relieves the low surface temperature, but must be applied judiciously, because if too extreme it will carry the patient into heat exhaustion. The danger of burning a semi-conscious patient should always be borne in mind.

Respiratory failure is best treated by inhalation of oxygen and carbon dioxide, as mentioned in considering acapnia. If the patient is seen during the stage of rapid respiration, rebreathing should be instituted. A paper bag or a closed cone held tightly over the mouth and nose for a minute or two is a simple apparatus for this treatment.

The use of salt solution is the general routine method for treating shock, therefore a few suggestions regarding the manner of its administration may be valuable.

The solution should always reach the body at a temperature a few degrees above 100° F., and special care is necessary to have the heat nearly uniform. The strength of the solution should be isotonic, i. e., .9 to .94 sodium chloride. The presence of a small quantity of potassium .03, and of calcium .01, is an advantage, but is not essential. When given subcutaneously or by the rectum, slight variations in the strength of the solution are not important. Howell finds the response to alkaline sodium carbonate solutions marked and prompt. This solution should be tried, therefore, when the ordinary salt solution seems unavailing.

Intravenous infusion is a more difficult method than either of the other means of administering salt solution, but at the same

time it is also more rapidly beneficial. We reserve this method, however, for use in cases of severe shock, those in which the blood pressure falls to the neighborhood of from 40 to 60 mm. Hg. Intravenous infusion is best given in the median basilic vein, either exposing the vessels through an incision, or plunging the needle through the skin directly into the vein. In either case a moderately tight tourniquet applied about the arm makes the vein more prominent and easier to enter. The solution must be allowed to flow in slowly and the heart's size and action carefully noted during the administration. Any evidence of cardiac dilatation is a sign that the solution is being given too rapidly, or in too large quantity.

We know that in shock the secretions are diminished; also that there is a transudation from the vessels, the latter condition also occurring whenever there is much hydremia. Therefore, it is our endeavor to give intravenously that quantity of salt solution which will give the greatest stimulation to the vital centers and at the same time prevent embarrassment of the heart, due to overfilling the vessels, while avoiding a degree of hydremia that will lead to transudation. (Experimentally, about 5 c.c. of salt solution for each pound of body weight.) After hemorrhage the quantity can be increased.

Subcutaneous infusion is used as a preventive of shock in long operations or after hemorrhage, and as a remedy in those cases of shock when the blood pressure is between 60 and 70. The solution is given into the loose areolar tissue under the breast, of the buttocks, thighs or back. It should be given slowly, under very slight pressure by gravity. It is bad practice to pump large quantities of salt solution into the tissues, with the formation of an enormous wheal. The pressure on the neighboring vessels interferes with absorption, and is likely to lead to necrosis and sloughing. The speed at which the solution should be given depends on the rapidity of absorption, and should never be great enough to lead to more than a very slight distention of the tissues.

Rectal infusion (proctolysis) is most valuable as a prophylactic measure, although it is an aid in treating milder degrees of shock. For prophylaxis the solution is allowed to flow in slowly, about 40 to 60 drops a minute, the object being to have the rate of flow equal to that of absorption from the rectum.

For treatment, the solution is given more rapidly—about 500 c.c. being injected into the bowel in a few minutes. By the use of a long tube the fluid may be carried directly into the upper colon, and the area for absorption thus increased. The addition of an infusion of coffee to the rectal salt solution is an advantage.

Direct transfusion of blood. This method of treatment is more often used for hemorrhage than for pure shock. It is of value, however, and in severe shock should be employed whenever a donor can be found.

DEAFNESS—ITS CAUSE AND NEWEST TREATMENT.

By *H. E. Cook, M.D.*,

New York, N. Y.

Formerly Chief of Clinic St. Bartholomew's Ear Department, Attending Surgeon
New Amsterdam Eye and Ear Hospital, Assistant Surgeon Ear
Department Cornell University Dispensary.

IN presenting this subject it is my earnest purpose to impress upon the general profession and the general public the enormous importance of the correct treatment and also the correct preventive method of treatment for catarrhal deafness.

While credit must be given for the least advance, the general profession will bear me out that aurists, as a rule, are dismal failures as regards the treatment of chronic deafness. The ear specialist of today offers practically nothing to the person suffering from catarrhal deafness notwithstanding the fact that nineteen out of every twenty cases of ear trouble are chronic catarrhal deafness.

The fact that so little has ever been accomplished by the specialist gives the charlatan a splendid opportunity.

Hearing, which is next to sight in importance, has gained absolutely nothing as regards beneficial treatment. Cases are being treated exactly the same as was advocated 35 years ago, and that brings us back to the time of Professor Politzer, who introduced the Politzer bag for the treatment of middle-ear deafness. It was and still is in a measure, as far as relates to the present methods employed by aurists, the only real and successful means of treating the ear. Even this, though very meager in its results and slight in its scope, has accomplished much.

To mention the hundreds of useless instruments that have been thrown upon the market and introduced to the public simply for a monetary return would be a waste of valuable time.

The person who reads this article will be one who is sufficiently interested and knows the absolute uselessness of the present methods of treatment and the ineffective instruments that have been imposed upon the public. The laity are disheartened with the various unsuccessful methods used to give them relief. The ear specialists themselves are actually in despair. Any honest specialist, if you demand a frank and decisive statement, will say that he despairs of ever producing any material results in these cases. It is a great misfortune that conditions are allowed to exist which encourage the suffering public in their eagerness to get relief to be so easily imposed upon by the charlatan and irresponsible medical man.

To make my arguments a little clearer I will enter into a little more detail on:

What is deafness?

What is the cause of deafness?

What can we do with a patient who has acquired deafness?

We find these *conditions* in young and old. *Most cases start with infancy, as a rule.*

The young infant may be born with abnormal conditions, which I shall state later. This would predestine the child to catarrhal deafness. The infant may be born with all the organs perfectly normal, but through a series of nasal involvement develop a condition called adenoids, which is practically hypertrophy of lymphoid tissue at the back of the nasal cavity, also enlargement of the mucous membrane lining of the nose. This condition can result even after the most careful attention given by the parents of the child. A diagnosis can be readily made even by the merest tyro on medical subjects. The child would breathe with his mouth open, snore at night, toss and become worried during sleep. Dullness of intellect as well as dullness of hearing and running ears develop. These conditions may or may not accompany or precede scarlet fever, measles and diphtheria. The hard palate (roof of the mouth) will show a very high arch. There will be a broadening at the base of the nose, producing a condition known later in life as "frog face." In the older child the teacher will notice the child appears listless and inattentive, and takes him to be dull of intellect. His speech will be interfered with, giving a nasal twang.

The mechanical effect produced by the adenoids will be to obstruct the orifice of the Eustachian tubes, preventing a proper drainage of the fluid of the mucous membrane lining of the middle ear and of the eustachian tubes, and at the same time preventing an equality of air pressure in the middle ear, which is absolutely essential so the ear drum may remain highly sensitive and responsive to the most minute vibrations, and this is necessary for most acute hearing.

If a condition of adenoids does not exist, but an overgrowth (hypertrophy of the turbinate bones) has existed at any time during youth or childhood or a spur of the septum, a similar condition of affairs may result, possibly not immediately, but gradually, and will simulate a condition that will be produced by adenoids itself.

Granting that this condition of adenoids, hypertrophied turbinates and spurs of the septum and with the subsequent nasal catarrh which follows have existed with the child for a year or a number of years or with an adult without their removal by operative measures the patient will exhibit the following symptoms as regards catarrhal deafness: Head noises, such as tinnitus, parencusis, "hearing better in a noise," diplacusis, conversational deafness, which the layman associates with deafness and with which the general physician is fully acquainted. In some instances splendid hearing on the telephone, but partial loss of conversational hearing. An examination of the ear in these cases will show partial or complete retraction of the ear drum, partial or complete absence of the drum due to suppurative processes, a thickened or thinned drum membrane, contracted or collapsed condition of the eustachian tube, partial fixation of the stapes, etc. Any of these pathological conditions may be present and still the patient may

show what is known as excellent bone conduction, signifying a perfect or nearly perfect perceptive apparatus (an auditory never undamaged).

What does the aurist do? What can he do? If adenoids are present it is absolutely essential to remove that condition by operative methods. In my opinion, there is no operation in the whole domain of medicine that is attended by happier results than this simple operation for the removal of lymphoid tissue or adenoids. If there is a condition of overgrowth of the turbinate bodies in the nose, their partial removal is followed by gratifying results; also the same results follow in cases of hypertrophied tonsils.

With all the *causes directly or indirectly responsible for deafness* removed as far as possible, treatment then resolves itself into the proper method of producing the long neglected but natural vibrations of the middle and internal ear.

The ear feeds on sound, the same as the muscle does on exercise or the body on food. Take away exercise from the muscle, and it atrophies. For example, place a fractured arm in a splint for six months, or, better still, place an arm in a splint for six months that has had no injury, and after removal of the bandage and splint it is found physically impossible to use that arm in any way, and it requires months of constant massage to bring it back anywhere near its former condition.

The same condition exists in the ear relatively. Take away sound from the ear by mechanical means or otherwise, and an atrophy of the integral parts of the middle and internal ear results. The chain of ossicles become stiffened, the ear drum becomes thickened and inactive, and the vibrations which should be sent directly to the perilymph of the internal ear do not reach their destination in their proper intensity. When the perilymph is made to vibrate normally it has the appearance, for example, of throwing a pebble upon a pond of water, but if the vibration that is sent in is diminished in quantity the series of concentric vibrations are limited in their scope, and the diminishing of these vibrations is similar, for example, to pressing your finger on the sound box of a phonograph, though ever so lightly. This would cause the pin which plays upon the record to come into too close contact with the record, thereby altering the sound and slowing the transmission of the sound. In the ear we have a similar effect. The pressing of the ear drum ever so lightly upon the ossicles causes a stiffening of the joints of the ossicles and its mechanism, producing a pressure upon the oval window which leads to the internal ear, thereby rendering it necessary to have a greater amount of sound to set the drum, the ossicles and the perilymph in action. This will be noted from the simple fact that when a person is deaf from catarrhal deafness you must speak louder to make them hear or make them hear well. Also you will note that persons suffering from catarrhal deafness hear better in a noise, for instance, on a train. This is caused simply from the fact that the ossicles and the perilymph are set ready for action by the vibration as they should be normally.

then the sound is transmitted without interference and the person hears perfectly, whereas persons of normal hearing do not hear at all, or very slightly. The fluid that is in the internal ear, called perymph, becomes inactive in turn, thereby not performing its proper function.

The primary cause of a contracted ear drum, then, is a contraction or closure of the eustachian tube. The closure of this tube shuts off the air that is in the middle ear from the nose. The mucous membrane lining the middle ear has the distinctive property of absorbing oxygen from the air. In the instance of closure of the tube the oxygen is absorbed, leaving only part of the original air in the middle ear, thereby producing a partial vacuum. If this condition is allowed to remain for many months the ear drum is pushed in by the external atmospheric pressure, which is greater than the pressure in the middle ear.

Then the most important thing is to equalize the pressure on either side of the ear drum, to supply the proper amount of oxygen to the mucous membrane lining the middle ear, to send in air and oxygen in a heated form, that is at least the body temperature, on account of the extreme sensitiveness of the organ of hearing, to produce a visible and mechanical movement by means of air vibration of the ear drum and the chain of ossicles, and the visible and positive vibration of the perymph in the internal ear.

This visible and positive vibration of the perymph must imitate the natural vibration which takes place in the internal ear following sounds of all varieties. In other words, we must produce vibrations of the ear which will influence the internal ear the same as all tones, all natural voice tones, all musical tones and all external vibrations which correspond with ordinary every-day sounds; in other words, producing vibrations practically from 36 to 500 or even 1000 per second.

To accomplish this result I have devised and perfected a series of instruments which now work automatically, positively and effectually producing these results and *through the eustachian catheter*. I will gladly demonstrate the immense value of this instrument at any time.

With this arrangement air or oxygen, or both, can be sent through the eustachian catheter in a heated form at the body temperature, or even higher, being vibrated at the same time.

At the same time we are able to produce a positive pressure increasing the intensity of the waves and a positive suction or suction and pressure automatically rarefying the air in part and producing different sound waves. The pressure or suction can be sent in at any speed or pressure, producing certain required results.

The results obtained are true sound waves of varied intensity. High and low tones corresponding to the surrounding natural sounds are sent directly into the middle ear, producing a complete and harmless vibration of the walls of the ear and chain of ossicles; also the vibration of the round and oval windows, and finally vibration of the fluid in the internal ear.

The results following the treatment are definite and positive. A frequent statement of my patients receiving this treatment is that "the vibration seems to have reached the spot." Head noises are influenced almost immediately. It produces clearness and general sense of improvement that inspires the patient.

Following this treatment there is usually a dullness of all hearing for several hours, which is followed by decided improvement, that is, in the mild cases. In the more severe cases the dullness may remain for 12 or 24 hours, but after a few treatments this dullness entirely disappears, and is followed by general improvement.

It would give me great pleasure to demonstrate to any of the medical profession the working of these instruments, and to demonstrate their availability for the treatment of catarrhal deafness. It is not a patented article, and is available to the medical profession.

501 Fifth avenue, New York city.

SCIENTIFIC FEATURES OF MODERN MEDICINE. By Frederic S. Lee, Ph.D., Dalton Physician of Physiology, Columbia University. New York: the Columbia University Press. 1911.

Professor Lee is of the opinion that the number of non-believers in the efficiency of medicine would be greatly lessened if properly supplied with literature on medical subjects in plain, non-scientific English. He rightly says the labors of a learned profession can easily be belittled by those who are less learned. The purpose of this book is to bring in plain words to the attention of the intelligent laymen what medical men have accomplished in preventive medicine, diagnosis, treatment, etc. Herein is contained a short sketch of the normal human body, the nature of disease and the methods of diagnosing and treating disease, bacteria and protozoa and their relation to disease, the treatment and the prevention of infectious diseases, features of modern surgery, the rôle of experiment in medicine and the public and the medical profession.

Some people expect medicine to do the impossible, and because it fails occasionally they become skeptical, and are ever ready to condemn all efforts of the profession as fraudulent and inimical to the public weal. We are well aware that some women and old-maid men with fancied diseases have been brought into a better state of mind, therefore body, by suggestion when medicine has apparently failed, but this failure cannot be charged up to medicine, for in most instances the patient has been told there was nothing the matter with him. It is not, however, so much with this side of the question that the book deals, but with what scientific medicine has actually accomplished. Any unbiased layman who will read the book with an open mind will get an entirely different idea as to what medicine has accomplished.

REMARKS OF THE RETIRING PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY AT THE INAUGURATION OF DR. HUGH HAMPTON YOUNG.

By Franklin Buchanan Smith, M.D.,

Frederick, Md.

At the opening of the twelfth year of the twentieth century and the beginning of the thirteenth anniversary of the second century of the foundation of this faculty, it is a matter of sincere congratulation to us all to look back upon its past. Some of our members, because of youth, can only do this through the pages of its written history, or through its traditions; others of us, through the actual experiences of long personal service in helping to form its past history and in shaping its future destinies.

All, young and old, however, meet this night with joyful retrospection of the past and the most hopeful anticipation and confidence in its future.

The medical profession in the past 10 years, as no other profession, has progressed and developed. With every advance of science and art it has kept abreast.

In its obligations to the private citizen it has neglected nothing that could be demanded of it, and to the general public it has offered an example of unselfish interest in its welfare, unequalled by any other body of organized men.

As the organized and official representative of all that is good in the medical profession of the State of Maryland, this faculty has afforded to its members that cordial support and encouragement so necessary in the pioneer endeavors of earnest workers in new fields. Under the shelter of its wing it has left no stone unturned to assist the efforts of those attempting to place our profession among the exact sciences and to afford sympathy, protection and encouragement to those developing new enterprises for the benefit of the profession or humanity in general.

This Medical and Chirurgical Faculty is no longer simply a medical debating society, no longer an organization intended only to protect its members from heresies and schisms in its midst. It is an organization *pro bono publico*; for the whole public, the State at large and its citizens.

To its aid it calls, and in turn it aids, not only its own membership, but every religious, political and social influence in attaining results beneficent to the human race. In fact, it is in close touch with, or is actually itself, the leader of every scheme of philanthropy and in every plan for the protection of the general public in preventing crime, warding off disease or in the amelioration of the condition of the unfortunate sufferers of the consequences

of crime, or in the mitigation of the pangs of those overtaken by sickness.

It guides the economist by affording a correct diet and regimen upon scientific basis for the support of the human mind and body at the least cost, and with the least waste, and protects the public either through laws or warnings of impurity in food and drug.

Much more could be said showing how this faculty, until recently a medical organization for self-protection and improvement, has rapidly developed in late years into an institute for the protection and improvement of society at large in every moral, hygienic and economic scheme of progress.

That all of this change, from a private professional organization to a public academy of scientific endeavor, has been brought about so rapidly and with so little change from the ancient landmarks of this body is indeed great reason for congratulation. Why now should we not indulge in anticipation for the future and build high our hopes.

The good work has only begun, and, having essayed to lead, there should be no step backward taken. We can teach the public and gradually unfold to it the precious truths in our possession for their benefit. It may suspiciously at first receive these truths and grudgingly and slowly assimilate this knowledge; it may even sometimes pervert and misconstrue, but it will never forget.

Today educated by us, the public, having learned some truths in preventive medicine, clamor for more knowledge, more efficient and sterner laws to stamp out or prevent communicable disease. To this end we must labor, or that same public will urge us on.

Having diffused some knowledge of the difference between pure and adulterated food and drugs, whether actuated by the selfish desire of procuring the proper return for their money or the correct appreciation of the value and dangers, respectively, of purity and impurity, they nevertheless loudly demand more protection and legislation along this line. They look to us for leadership. We must advance.

The inability of unscientific endeavor to overcome social problems, either through moral suasion or religious teachings, the futility of laws enacted for social hygiene and sexual prophylaxis at this time and the growing realization of the people to the fact that the welfare of the State—and the human race is intimately connected with this subject—calls forth a demand for the suggestion of remedies from whom? From the medical profession. We have started this work; we must not relax; we must keep on.

Lastly, we have advised the public of newer and improved methods of caring for those until lately considered hopeless and hence consigned before death to the tomb—the tubercular and the insane.

They trusted us, and, taking into consideration the radical measures advocated, gave us generous support. The results of our practical demonstrations have more than made good our promises.

The public desires of us continued and renewed activity along these lines.

And now for my valedictory. Elected nearly two years ago to the highest office in your power to bestow upon me, I naturally felt great timidity upon entering upon duties so new to me and undertaking responsibilities as great as this high office entails.

My pleasure of preferment was tempered much by my fear of incapability to measure up to the expectations of my friends, but at the conclusion of my labors, whatever may have been your disappointments in placing me at your head, no murmurs of discontent or anything to mar the even tenor of my administration has reached my ears. My term of office, if uneventful, has been peaceful.

Having never before thanked the members of this faculty for its evidence of good-will and confidence, I do it now, and with ever-increasing love for it and faith in its future, I turn over its official management to my successor, than whom none more worthy of this high office exists among us.

SWAMP FEVER IN HORSES. By L. Van Es, E. D. Harris and A. F. Schalk. North Dakota Agricultural Experiment Station (Department of Veterinary Science), Fargo, N. D. 1911.

The present pamphlet is a summary of the investigations carried on by Es, Harris and Schalk in an endeavor to determine the cause of swamp fever in horses, which has been prevalent for the past few years in the Northwest. It is uncertain when and where the disease first made its appearance, but was noted in Manitoba in 1881, at which time it was confined to the country bordering on the Red River. Since then it has spread from its original habitat all over Manitoba, and in some instances into the States of the Northwest. Its name plainly indicates that it is most prevalent in low, marshy country, and occurs most frequently during the summer months. The writers then describe their experiments and those of others to determine the etiology, pathology and treatment of the affection. The writers were able to transmit the disease from a typical chronic field case by intravenous injection into a healthy animal. As they were unable to recover any organism, they were forced to the conclusion that the disease is caused by an ultra-microscopical virus. They then give the anatomic changes. As regards treatment, they say little can be expected from medicines, in their opinion prevention by isolation being the better procedure, supported with artificial immunization when a method is found.

THE SYDENHAM HOSPITAL UNDER THE MANAGEMENT OF WARREN P. MORRILL, M.D.

WHEN Dr. Morrill came to Baltimore November 15, 1908, the conditions at Sydenham Hospital were probably more discouraging than those the average hospital superintendent is called upon to face. The buildings were unfinished, and the ground in the same torn-up condition that the men who excavated for the buildings and sewers left it. The residence for the superintendent, which had been promised would be erected on the grounds, was then, and is today, still but a promise. Slop hoppers had not even been considered by those who planned the details of the ward building; and many similar details, absolutely imperative for systematic operation of the hospital, were lacking. Dr. Morrill took hold at once, and had one of the large wards cut up into three small observation rooms; had the stationary washbowls removed from every bathroom and slop hoppers installed in their places. The sidewalks were laid; a driveway to the stable was made; grading was done to level off hillocks and holes left by the builders and contractors and to afford surface drainage; the fixtures of the diet kitchen, linen room and laboratory and pharmacy were installed, and the thousand and one little things necessary for the successful running of the hospital placed in readiness for use.

These mechanical details all received careful attention, but the greatest thing that was done at this early stage of the hospital, while no patients were being received, was the provision by Dr. Morrill for a complete system of clinical records and a comprehensive system of cost accounting and distribution. This system, modeled after the system first proposed by Dr. Irving Fisher, superintendent of the Presbyterian Hospital of New York, and later adopted by the National Hospital Association as the report of its Committee of Uniform Accounting, is a distinct feature of the hospital, and one which the average physician, be he ever so clever a practitioner and ever so competent as private physician, would hardly install unless he were thoroughly equipped for his position of hospital superintendent by experience in other hospitals. By it the superintendent can at any time tell the absolute cost per unit of any department of the hospital's activities, and thus guard against any leaks or waste of material. As the years pass such a system becomes invaluable as a means of comparison, and a gauge whereby the increasing expenses may be proportioned with the increase in size of the various departments.

The first case entered the hospital April 5, 1909. This was a child from the Maryland School for the Blind, and from that time on the calls made by various institutions have filled the ward. There are 34 beds at Sydenham, and one institution at one time wished it to accept 39 cases of scarlet fever. During the months of January and February, 1911, it was impossible to receive a

single patient from private homes, as the calls made by institutions alone could not be met, owing to the inadequate facilities of the hospital. The hospital has never been able to accept cases of measles, and one of the things most strongly recommended by Dr. Morrill in his first report was the addition of a ward for this disease, and another ward for miscellaneous infectious diseases, to include mumps, chicken-pox, erysipelas, whooping-cough, etc., which are refused by other hospitals.

An appropriation of \$30,000 was made by the City Council of Baltimore for an additional ward building to be erected imme-



DR. WARREN P. MORRILL,

Formerly superintendent of Sydenham, and now superintendent of Winnipeg General Hospital, Winnipeg, Manitoba, Canada.

diately, this appropriation being made in October, 1910. To date the plans have been prepared. It is hardly to be hoped that this new ward can be successfully operated unless some plan is worked out for nurses' quarters.

The Sydenham has suffered; first, in its location. It will be long before the idea can be eradicated that it is a part of Bayview Asylum, and many patients who were unable to pay for medical attention have preferred to suffer to going to an institution popularly supposed to be only for paupers. The charitable workers

of the city have been not altogether blameless in this regard. One instance is cited. A man died, and the papers published that he died in Sydenham, whereas he really died in the hospital at Bay-view. This man's wife was called up, and it was stated to her that he had never been to Sydenham, and she replied that when he left her home the charitable worker, who urged his removal, had stated that it was Sydenham to which he was being taken. Many of the ignorant classes repeat this and similar stories, and a stigma clings.

The buildings are not properly constructed, and are literally falling down, in addition to being wholly inadequate. The suggestion that new buildings be added, one at a time, is not practical, because the administrative and laundry buildings and heating plant are unable to do any more than they are at present.

A home for nurses is sadly needed if the hospital is to increase in size. The suggestion that the nurses live in the wards will not be tolerated by the best nurses, and were they to offer no objections, such living quarters would not be conducive to the best work on their part. At present the nurses live in the administration building and over the laundry. The administration building has been patched and patched, but still leaks badly on rainy days, and often showers plaster upon the sleeping nurses.

The size of the hospital and the special character precludes the possibilities of a training school for nurses for many years. Therefore, graduate nurses must be employed, at a much greater cost than if pupil nurses were doing the work.

The hospital should be run by a competent superintendent, regardless of his politics. It would perhaps pay the City of Baltimore to secure a superintendent with long training in a contagious ward of a large hospital, pay him a good salary, and let him run the hospital. Needless to say, politicians are not exactly competent hospital executives, and it would behoove the city to entrust such matters to the hands of a man whom other cities have similarly trusted. Where the health of the community is concerned, political aims should absolutely play no part, and conflicting parties should unite to secure the person most competent to guard the health of the community. In ordinary hospitals we believe the better plan to be to secure a competent man as manager of the hospital and to pay him a good salary, and there will be no difficulty in securing a medical graduate who will serve under him without salary for the experience gained. But this plan could not be carried out in a contagious-disease hospital.

We would also suggest that the recommendations of Dr. W. P. Morrill, in his report for the year ending December 31, 1910, on pages 8 and 9, be accepted in their entirety, with the exception of the manner of raising the finances, which, as medical men, we consider a question which we should delegate to the hands of municipal financiers.

We are happy to endorse the administration of Dr. Morrill, and

to publish his views for the future of Sydenham as below outlined:

"The needs are, first, the adoption of a comprehensive plan of expansion and a methodical carrying out of such plan. The policy was said to be to add one building per year, but three years have elapsed without the addition of a single building; but even though that had been carried out, it would have been unsatisfactory, for the reason that it would always be out of balance—that is to say, the wards would have greater capacity than the heating plant could care for or the administrative end properly attend to. The only sensible manner in which to approach this need is to appropriate a sum sufficient for a completed group along some such comprehensive plan. Addition by units will never be successful.



VIEW OF THE FOUR BUILDINGS AT SYDENHAM.

The ward building is built of brick. The other three are poorly constructed of wood.

"From the administrative standpoint it would seem unwise for the city to own and maintain two hospitals separated only by imaginary lines in the middle of the street, not only under separate local administration, but under different departments of the city government. The hospital section of Bayview, the present proposed tuberculosis hospitals and the Sydenham Hospital should be combined in one single municipal hospital, and if such a thing is possible in Maryland this should be removed from politics. As a rule, it has been found that municipalities either do not pay a sufficient salary to bring the man best fitted for the place to it, or when they do they surround him with conditions which a competent man will not tolerate. There are, however, sufficient exceptions to this rule to indicate that it is possible to obtain a capable super-

intendent, provided the municipal government is imbued with the proper spirit.

"Judging from other cities, it is probable that Baltimore needs not less than 250 beds for the minor infectious diseases, not including venereal diseases nor any of the diseases now admitted by general hospitals. It is likewise probable that as research gives us more definite information as to the causation and manner of spread of diseases now admitted to the general hospitals, we will consider it necessary to isolate a larger number of diseases than we now do, and the expense of maintenance of adequate quarters is such that it is not probable that it will be undertaken by any of the privately-endowed institutions. More than this, it is essentially a municipal duty to maintain sufficient facilities for these cases, not so much for the treatment of the individual as for the protection of the well.

"While not at all apropos of the subject, I consider that the time when a venereal hospital for Baltimore will be seriously considered is not far distant, and that the cost of its establishment and maintenance will be more than offset within a short period by reduced appropriations for blind and insane asylums."

SOME ROUGH NOTES ON MODERN DIAGNOSTIC METHODS. New York: The Fellows Company.

This little pamphlet has been issued as a result of the favorable reception accorded their previous pamphlet, "Some Posological Hints and Other Useful Information." The present publication contains an infinite amount of information in condensed form concerning the clinical examination of the stool, sputum, transudates and exudates, the Widal reaction, the Wasserman reaction, blood pressure, local tuberculin reactions, leucocytosis, etc. The publication will be found extremely useful as an aid in laboratory work. We predict for it a more cordial reception than that accorded its predecessor.

THE PHYSICIAN'S VISITING LIST (LINDSAY AND BLAKISTON'S) FOR 1912. Flexible leather. Philadelphia: P. Blakiston's Son & Co. \$1.25 net.

Blakiston's Visiting List needs no introduction, and the sixty-first edition will be found as useful as its predecessors. Besides space for the entry of 25 new patients weekly, it provides for the listing of addresses of patients and nurses, bills and accounts asked for, vaccination and obstetric engagements, births and deaths and cash account. Besides these features are a calendar for 1912 and 1913, a table for the calculation on the period of uterogestation, a synopsis of the immediate treatment of poisoning and a physician's dose table. Its size and neatness of appearance should appeal to prospective buyers.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE DECEMBER (1911) EXAMINATIONS.

THERAPEUTICS.

1. Give therapeutics of hypodermoclysis and method of administration.
2. Write a prescription in Latin, without abbreviation, containing four ingredients which you would use for an acute bronchitis, and give directions for using same.
3. Write a prescription in Latin, without abbreviation, containing three ingredients which you would use for diarrhea, and give directions for using same.
4. Give the therapeutics of eserine and usual method of administration.
5. Give therapeutic uses of three zinc salts, and name antidotes for zinc poisoning.
6. Name the official preparations of oxygen, and give their therapeutic uses.
7. Give the therapeutics of three preparations of ammonium, and name them.
8. What is meant by a "gastric tonic" or "stomachic?" Give indications for use and mode of action.
9. Give the therapeutics of H_2O , hot and cold.
10. Give the physiological action and therapeutics of aconitum.

ANATOMY.

1. Describe the occipital bone.
2. Name the carpal bones.
3. Name varieties of articulations. Give example of each.
4. Give origin and distribution of great sciatic nerve.
5. Give origin, insertion and nerve supply of quadratus lumborum, brachialis anticus, orbicularis palpebrarum and sartorius.
6. Describe the epithelium of the pharynx.
7. What glands are in the small intestines, and where located?
8. Describe a villus. What is its function?
9. What arteries form the circle of Willis?
10. What and where is the pituitary body?

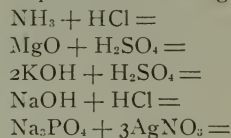
CHEMISTRY.

1. Define (a) reagents, (b) valence, (c) crystalloid, (d) colloid and (e) atom.
2. Give the chemical name and composition of "laughing gas," how it is obtained and what are its properties.
3. Give one chemical antidote for each of the following: (a) Antimony, (b) lead acetate, (c) cocaine, (d) morphine and (e) phenol.
4. Describe in detail the examination of a

sample of urine for the detection of bile, sugar and albumin.

5. (a) What are metals? (b) What are non-metals? (c) What are amalgams, and (d) what are indicators?
6. Give the chemical formula of each of the following: (a) Nitric acid, (b) boric acid, (c) sodium bromide, (d) zinc oxide and (e) calomel.
7. What is glycerine? What is its source in nature? How is it obtained, and what are its properties?
8. (a) What is an alcohol? (b) What is an alkaloid? (c) What is a salt, and (d) what is a hydrocarbon?
9. Give the "law of constancy of composition."

10. Complete the following equations:



OBSTETRICS.

1. Name the sutures of the fetal head.
2. What precautions should be taken against septic infection during labor?
3. Indications for use of forceps and mode of application.
4. What are the objections to the use of ergot and stimulants in labor?
5. How would you prevent perineal tears during labor and delivery?
6. What are the varieties of placenta previa?
7. Outline the care of the navel.
8. Describe some of the best substitutes for mother's milk.
9. What are the different forms of endometritis?
10. Mention the varieties of vaginitis and their treatment.

MATERIA MEDICA.

1. Iodine—How obtained? (b) The official preparations?
2. What is black wash? Yellow wash? (b) What are wines? (c) What is the difference in the preparation of lozenges, tablets and triturates? Name some of the official lozenges.
3. What is the difference between anesthetics and anodynes? Name some of each most generally used. (b) What is the difference between liniments and lotions? Name some of the official.

4. Give the average dose of tincture of aconite, tincture of *nux vomica*, tincture *digitalis*, tincture *opium*, tincture *veratrum*.

5. To what class of drugs does bismuth belong? What are the official preparations and doses?

6. What is the difference between irritants and counterirritants? Name the most important.

7. Name six preparations of iron and their doses. (b) What are the incompatibles of iron?

8. Write a prescription containing iron, arsenic, strychnine and quinine, using the official terms, and state when best administered.

9. Write a prescription containing tincture aconite, sweet spirits of nitre, spirit of Mindererus, using the official terms.

10. Silver—Its official preparations and doses? What are the incompatibles of silver?

PHYSIOLOGY.

1. What is meant by the physiological effect of a drug?

2. Into what general classes are foods divided? (b) Give examples of each.

3. What effect has starvation upon the proteids?

4. What is animal heat? (b) What relation exists between the temperature of the body and the pulse? (c) What is the difference between warm and cold-blooded animals?

5. What is meant by nerve cells and nerve fibers? (b) Define afferent, efferent, trophic, inhibitory, motor and vasomotor nerve fibers.

6. What is meant by diffusion and osmosis?

7. What is meant by absorption and nutrition?

8. Which organs of the body secrete, and which excrete?

9. Describe the method of producing artificial respiration.

10. What is the composition of saliva, gastric juice, blood and urine?

PATHOLOGY.

1. *Ascaris lumbricoides*—Describe briefly life cycle and characteristics. Mention two or more dangerous conditions brought about by infection with this parasite.

2. Mention at least four varieties of ulceration seen in the gastro intestinal wall. Describe the gross appearance of an amebic ulcer.

3. What are the dangers inherent to diseased tonsils?

4. What is meant by active congestion? Passive congestion? Give an example of each.

5. Trace the probable course of events which follow chronic obstruction of the urethra.

6. Given a slide supposed to be smeared with gonorrheal pus, how would you proceed to establish the fact?

7. On what principle does vaccination against typhoid fever depend? How is the vaccine prepared?

8. Describe the process of repair in an uninfected fracture of bone.

9. Describe the exudate in a pneumonic lung in the stage of red hepatization.

10. Define, explain and give examples of exudate and transudate.

SURGERY.

1. Name the varieties of fractures of vault of cranium. Prognosis and treatment?

2. Name the different varieties of fractures, their etiology, symptoms and complications.

3. Give a classification of dislocations with the etiology, predisposing cause and anatomic peculiarity of each.

4. Give indications for operative treatment of fractures.

5. Give the early diagnosis of exophthalmic goitre.

6. Differentiate between obstruction of common and cystic ducts.

7. Describe glaucoma. Give signs and treatment.

8. Define hematoma, aneurism, thrombus and embolus.

9. Indications and contraindications for salvarsan in treatment of syphilis? Technic of your method of administration.

10. Causes and treatment of acute otalgia?

PRACTICE.

1. Define (a) Von Graefe's sign, (b) uremia, (c) arterio sclerosis, (d) cirrhosis of the liver, (e) angina pectoris.

2. Define (a) dysphagia, (b) hematuria, (c) hemoptysis, (d) laryngismus stridulus, (e) pertussis.

3. What diseases most commonly occur in the right inguinal region?

4. Differentiate neuritis and rheumatism.

5. Differentiate diphtheria and acute follicular tonsillitis.

6. Differentiate rubella, rubeola and scarletina.

7. Differentiate intestinal colic, uterine colic and renal colic.

8. Give treatment of angina pectoris.

9. Give treatment of lobar pneumonia.

10. Give treatment of acute dysentery.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, December 12, 13, 14 and 15, 1911.

No.		Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
1	Woman's Medical College of Pa., '10	80	..	67	..	75	77	75	87	70	531	59
2	University of Maryland, '11	75	95	81	94	82	85	75	82	80	749	83
3	College of Phys. and Surgeons, Balto., '10	75	95	92	93	75	88	94	92	85	789	87
4	Johns Hopkins, '08	65	85	86	93	85	72	75	81	96	738	82
5	University of Virginia, '02	76	84	93	98	91	84	78	89	80	773	86
6	Woman's Medical College of Pa., '11	72	78	55	80	78	75	55	67	80	640	71
7	University of Maryland, '11					Failed to appear.						
8	Howard University, '08	..	..	75	..	78	..	..	..	..	...	..
9	College of Phys. and Surgeons, Balto., '11	76	82	100	78	67	72	80	68	73	696	77
10	University of Maryland, '11	67	90	97	75	89	77	92	92	70	749	83
11	Maryland Medical College, '09	..	75	75	..	79	..	..	..	..	...	..
12	University of Maryland, '11	70	77	70	93	78	70	35	74	75	642	71
13	University of Maryland	92	..	..	..	..	91	80	..	95	...	..
14	Maryland Medical College, '10	46	70	57	60	59	89	40	69	50	540	60
15	Howard University, '11	57	73	63	79	75	60	55	69	70	601	67
16	Howard University, '11	71	85	77	85	85	73	78	81	75	710	79
17	Johns Hopkins, '09	79	80	93	97	83	75	60	82	90	739	82
18	Maryland Medical College, '11	..	..	84	..	82	..	77	..	75	...	..
19	University of Maryland, '10	..	..	77	..	88	..	..	..	..	...	..
20	Baltimore Medical College, '11	62	80	84	80	75	69	75	77	73	675	75
21	College of Phys. and Surgeons, Balto., '11	70	85	76	78	75	70	80	84	70	688	76
22	University of Maryland	84	..	..	..	..	87	76	..	75	...	..
23	College of Phys. and Surgeons, Balto., '11	84	78	70	92	81	81	85	86	85	742	82
24	University of Maryland, '05	46	..	50	..	..	..	..	..	85	...	..
25	Johns Hopkins, '10	80	98	99	98	93	87	80	98	95	828	92
26	Meharry Medical College, Tenn., '11	53	50	20	75	57	50	50	54	65	474	53
27	Maryland Medical College, '11	..	80	75	83	79	..	..	..	75	...	..
28	Baltimore Medical College, '11	42	80	83	78	81	60	58	84	75	641	71
29	Maryland Medical College, '11					Failed to appear.						
30	University of Maryland	83	..	..	..	..	84	77	..	75	...	..
31	Georgetown University, '10	78	85	89	89	82	88	75	100	96	782	87
32	Woman's Medical College, Balto., '04					Failed to appear.						
33	College of Phys. and Surgeons, Balto., '11	..	..	78	..	..	..	75	89	75	...	..
34	College of Phys. and Surgeons, Balto., '11	76	80	68	91	80	74	54	72	80	675	75
35	College of Phys. and Surgeons, Balto., '11	76	70	94	79	71	72	80	95	92	729	81
36	College of Phys. and Surgeons, Balto., '10	75	..	75	..	79	..	75	81	..	...	..
37	Georgetown University, '11	49	88	66	77	76	75	50	71	75	627	69
38	University of Maryland, '11	50	75	66	70	76	71	75	64	80	627	69
39	Baltimore University, '02	5	23	16	..	37	20	..	..	..	...	..
40	University of Nashville, '07	63	75	61	95	72	73	77	79	80	675	75
41	Johns Hopkins, '11	75	..	..	..	83	..	80	79	..	...	..
42	Maryland Medical College, '10	..	70	65	68	68	..	59	..	50	...	..
43	Baltimore Medical College, '11	68	80	57	80	75	80	76	73	60	649	72
44	Maryland Medical College, '06	68	..	63	..	..	..	..	..	..	...	..
45	Maryland Medical College, '10	75	..	75	..	75	..	..	..	..	...	..
46	University of Maryland, '10	87	85	69	82	77	82	54	80	60	636	71
47	University of Pennsylvania, '11	72	85	78	92	67	78	75	82	75	704	78
48	Baltimore Medical College, '08	67	85	75	83	65	55	64	73	75	642	71
49	Maryland Medical College, '11	75	81	69	75	80	76	83	86	75	700	78

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland law, students who, at the end of their second year, have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology, are entitled to examination by the Board of Medical Examiners in these branches. Ratings made by these students in the examination, which is known as the "second-year examination," are carried forward and made a part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

DROP FINGER, WITH REPORT OF CASE.

By Nathan Winslow, M.D.,
Baltimore, Md.

THE finger is heir to many injuries, some of which are common, others less frequently seen. Amongst the rarer injuries is the condition known as drop or mallet finger. Not having seen such a condition until recently, the writer believed it of sufficient interest to bring to the attention of the readers of the JOURNAL, so that when dealing with finger injuries they may bear in mind its possibility. As the name implies, there is a dropping of the terminal phalanx of the finger, as a result of either complete or partial rupture of the extensor tendon near its insertion, following a blow to the tip of the extended finger causing forcible flexion. The deformity may be merely a slight dropping or the bending may be as much as a right angle.

In recent cases the finger should be extended and a splint applied after thoroughly padding the parts. The splint should include not only the finger, but also the wrist of the affected hand, so as to thoroughly relax the tendon and thus favor union. If this procedure proves ineffectual, the tendon should be exposed by an incision, and the torn end sutured into the periosteum of the base of the terminal phalanx, and the finger and wrist immobilized as recommended above.

CASE.

Mrs. M. consulted me during the early part of last November (1911) about an injury she had sustained to the middle finger of her right hand which she had incurred by striking the tip against a board a few weeks previously. The blow was so severe that the finger felt numb, and on examination she noticed the end phalanx flexed and voluntary extension impossible. She was able, however, to straighten the finger with the aid of her other hand, but the deformity recurred as soon as the support was released. When I saw the patient the deformity was typical of the condition, and the diagnosis readily made upon the receipt of the history of the accident. Splintage in extension was ordered, and immobilization was maintained for six weeks. Now (January 22, 1912) the finger, though somewhat swollen and at times painful, is functionally perfect, voluntary extension and flexion being almost normal.

As this article goes to press Dr. J. Holmes Smith, Sr., informs me he is at present treating a similar case.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor.*

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BALTIMORE, FEBRUARY, 1912

THE LEAGUE FOR MEDICAL FREEDOM.

LATELY there has been much in the lay press from the secretary of this body of so-called public benefactors. All of us are undoubtedly aware that the press is the chief agent in casting public opinion. It therefore behooves every thinking physician to look carefully into the motives of this society. As far as we can discern, its chief concern is to open a back door for the entrance of every sort of nondescript into the practice of medicine. Of course, the members claim that their purpose is altruistic; that the society has been formed for the protection of the gullible public from the talons of the medical "trust," which "monster" has been creating all sorts of new diseases for the financial benefit of its members. The evident lack of medical knowledge by those most loud in the League of Medical Freedom is laughable, and the manner in which a layman who pretends to no knowledge of medicine has pointed out the glaring errors of its chief spokesman in Maryland has done much to bring discredit on the "Maryland Branch." Although reputable physicians in all ages have through their extraordinary ability been able to accumulate much worldly goods, still the rank and file have from time immemorial been poorly repaid for their services to their brother man, yet have been most willing to adopt and put into practice anything which tends to the lessening of disease—with its concomitant financial loss. If the medical "trust" were formed merely for gain, would it so insistently urge the preventive measures which have done so much to eradicate disease? The day of miracles is past; burnt offerings and sacrifices, incantations of the priests and the laying on of hands in dreaded diseases would no longer be tolerated by an enlightened public. Therefore, we can only draw the conclusions that this league, which claims to cure by such methods, is composed of self-seekers who

desire by continued publicity to secure the passage of laws enabling them to practice medicine—in a manner more healthful to their pocketbooks than the general interest of the community.

USE COMMON SENSE IN INFANT-FEEDING.

DURING the last few years there has been a marked tendency by the medical profession to discard complicated formularies in infant-feeding. This is indeed a welcome relief, as most of us have not forgotten our unnecessary expenditure of energy in acquiring this or that system of feeding. Americans have always been noted as faddists, and fall head over heels in adopting chimerical propositions set forth by leading lights without awaiting a thorough testing of new hypotheses. This characteristic has led them into many errors, in many instances to their sorrow. We have had somewhat the same experience in artificial feeding in babyhood. The modification of milk was carried to such limits that if it were not for the tragedy attached it would be laughable. In some instances the proteids, fats, etc., were so diluted that children were undoubtedly starved to death. All of us have no doubt seen children who were on the verge of death from inanition on modified diet as heretofore and even at present practiced immediately pick up and take on new life when a common-sense doctor ordered a discontinued fanciful modification and placed him on whole milk diluted one, two, three, etc., times, according to the indications of the case. As a matter of fact, we have been informed that teachers of pediatrics have almost entirely discontinued teaching their students systems for modification of this article of diet, and now impress upon the student the necessity of resorting to common sense in infant-feeding. They have come to realize that one child of a given age will thrive on whole milk, while another will need it decidedly diluted. There are no fixed rules, therefore, and each case must be studied individually. It has been found that the best procedure is to start the baby on whole milk diluted about four times and note how he thrives. If he manages such a dilution, but does not gain properly, then a larger feeding or a less dilute diet is ordered. We do not desire to convey the impression that scientific feeding has been without value, but that it has been carried in the past to ridiculous extremes. Undoubtedly, instances will still arise in which it can be employed satisfactorily, but the ordinary run of physicians will derive more satisfaction from the simple line of procedure outlined above.

Medical Items.

DR. JOHN R. WINSLOW announces the removal of his office to the Latrobe Apartments, Charles and Read streets, Baltimore, Md.

As an expression of their gratification at the decision of Dr. J. M. T. Finney to remain in Baltimore, a number of Baltimore physicians will tender him a dinner at the Belvedere Hotel February 12, 1912.

DR. BRICE W. GOLDSBOROUGH of Cambridge, Md., who has been quite ill with acute indigestion, has recovered, and is spending some time in Florida with Dr. Howard A. Kelly.

DR. EDWARD E. LAMPKIN of Nanticoke, Md., has been suffering with a fractured arm.

DR. WARREN P. MORRILL, who resigned as superintendent of the Sydenham Hospital, has accepted the superintendency of the Winnipeg General Hospital, Winnipeg, Manitoba, Canada. The hospital contains 350 beds, and is the great general hospital of the Northwest, as well as the teaching hospital of the University of Manitoba. We extend our cordial good wishes for success to Dr. Morrill in his new field.

CONSIDERABLE anxiety is manifested in the condition of Dr. Marcus L. Dillon, head of the surgical staff of the Franklin Square Hospital, who has been operated upon three times in an attempt to overcome blood poisoning incurred while operating.

DR. GEORGE HELLER is confined to his home with grip.

DR. CHARLES DE NANCREDE of the department of surgery of the University of Michigan is a patient in Johns Hopkins Hospital.

DR. H. F. SHIPLEY of Granite, Md., is at Mercy Hospital with three broken ribs as the result of being thrown from his buggy.

MARRIAGES.

ANTON GEORGE RYTINA, M.D., University of Maryland, '05, to Miss Catherine Gier, both of Baltimore, in Washington, January 24, 1912.

E. L. WILSON, M.D., Baltimore Medical College, to Miss Brooksie McClelland, both of

Baltimore, May 31, 1911. The couple will reside in New York City.

FRED S. WRIGHT, M.D., to Miss Ida M. Gesner of Baltimore at Wilmington, Del., July 10, 1911. The couple will live in McMechen, W. Va.

G. MILLER LOWMAN, M.D., of Romney, W. Va., to Miss Elva Pauline Gill of Baltimore, at Baltimore, January 17, 1912.

ARTHUR GILL TRACEY, M.D., to Miss Lulu M. Nolte, both of Baltimore, at Baltimore, January 17, 1912.

GEORGE WILLIAM SHIPP, M.D., University of Maryland, '10, of Newton, N. C., to Miss Bessie May Reid of Baltimore, at Baltimore, January 17, 1912.

WILLIAM B. COBB, M.D., of New Bedford, Mass., to Miss Olive M. Padgett of Baltimore, at Baltimore, January 24, 1912.

JOSEPH ANTHONY SOMERS, M.D., of Stoneville, N. C., to Miss Bettie Martin Brengle of Ridgeway, Va., at Baltimore, January 4, 1912.

JOHN H. ENGEL, M.D., of Baltimore, to Miss Marion Walsh of Philadelphia, in Philadelphia, January 17, 1912.

EDWIN BROOKS MAYNARD, M.D., U. S. A., University of Virginia, to Miss Catharine Lindsay Jarman of Charlottesville, Va., at Baltimore, January 22, 1912.

J. C. JOYCE, M.D., of Annapolis, Md., to Miss Kate McShane Jenkins of Baltimore, at Baltimore, January 26, 1912.

DEATHS.

HARRY BALDWIN GANTT, M.D., University of Maryland, '80, of Millersville, Anne Arundel county, Maryland, died, aged 54 years, at the University Hospital January 20, 1912, of pneumonia, following blood poisoning contracted from a patient upon whom he had operated.

CHARLES CORFIELD McDOWELL, M.D., University of Maryland, '74, of 1521 W. Fayette street, Baltimore, died at his home on January 24, 1912, after a lingering illness, aged 60 years.

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MARYLAND'S ANNUAL TYPHOID PROBLEM.*

By *C. W. G. Rohrer, M.A., M.D., Ph.D.,*

Baltimore, Md.

Maryland State Department of Health.

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INTRODUCTORY.

The title of my paper, "Maryland's Annual Typhoid Problem," is in itself highly significant. It implies that the typhoid fever situation confronts the people of Maryland annually; that it recurs year after year, to use a somewhat hackneyed expression, with monotonous regularity. But Maryland does not stand alone in this respect. If the old adage that "misery loves company" be true, then Maryland can solace herself with the thought that the annual typhoid problem confronts practically every State and Territory in the Union.

When the State of Maryland was yet young, the infectious disease problem confronted it. And this it has continued to do, gen-

*Paper read at the Seventh Maryland Conference of Charities and Corrections, held in Baltimore, November 27, 28 and 29, 1911.

eration after generation, decade after decade, down through the ages to the present auspicious moment. Like Banquo's ghost, it "will not down." Nor has age mellowed its existence, dimmed its vigor or mitigated its spread. On the contrary, typhoid fever, like tuberculosis, being largely a disease of modern civilized life, its virulence has seemingly increased *pari passu* with its years.

Of the four continued fevers—typhoid, typhus, relapsing and simple continued fever—typhoid fever is the only one ordinarily prevailing in this latitude. The word "typhoid" means "like typhus," and has reference to the drowsy, listless attitude assumed by a typhoid fever patient. The word "typhus" means "sleepy." Typhus fever is sometimes spoken of as "ship fever" or "jail fever." Typhus fever is unknown in Maryland at the present day, the last cases occurring in May, 1901. There were three cases, with one death.

II. HISTORICAL NOTE.

The medical history of Maryland may be said to have begun in June, 1608, when Dr. Wm. Russell accompanied Capt. John Smith, of Pocahontas fame, in his exploration of the Chesapeake Bay and his discovery of the Patapsco River. It is interesting to note that Captain Smith, in the account of his travels which he subsequently published, recorded some flattering things about Maryland. "Heaven and earth," wrote Captain Smith, "seemed never to have agreed better to frame a place for man's commodious and delightful habitation!"*

However, there was no permanent settlement in Maryland until the landing of the colonists at St. Mary's in 1634. For the next 120 years the people of Maryland were busy with Indian wars, with such epidemic diseases as typhus fever, dysentery, smallpox, influenza, yellow fever, cholera, measles and scarlet fever. Typhoid fever does not appear in these early records. The reason is obvious: Typhoid fever was not recognized as a distinct disease until the year 1829.† Previous to this date (1829) typhoid fever was confused with typhus fever.

The summer of 1756 was the hottest summer known in the early annals of Maryland. In that year (1756) typhus fever, dysentery and smallpox prevailed in epidemic form. This embarrassment, due to pestilential disease, must have been but temporary, because Thomas Jefferson, afterwards President Jefferson, in his Notes on Virginia, written in the year 1781, and in which he incidentally refers to the adjacent States of Maryland, Delaware and Pennsylvania, speaks in glowing terms of the salubrious climate, the healthfulness and the unsurpassed natural resources of Maryland.‡

*Captain John Smith: The Generall Historie of Virginia, New England, and the Summer Isles, p. 114. London, 1624.

†Typhoid fever was thus denominated by Pierre Charles Alexandre Louis, a celebrated French physician, b. 1787, d. 1872. He wrote "Recherches sur la fièvre typhoïde" in 1828. His researches were given to the medical world in 1829.

‡Thomas Jefferson: Notes on the State of Virginia, with map, including Virginia, Maryland, Delaware and Pennsylvania. London, 1787.

III. CAUSE OF TYPHOID FEVER.

Typhoid fever is due to a specific germ, the typhoid bacillus, discovered in the year 1880. Typhoid fever is sometimes called "drain fever," because of its frequent connection with bad drainage. Professor Sedgwick of Boston has characterized typhoid fever as "a disease of *defective civilization*," and exploits it as *prima facie* evidence of defective sanitation.*

Typhoid fever is transmitted from one human being to another through the following agencies:

1. Infected water.
2. Infected milk.
3. Infected fruit and vegetables.
4. Infected oysters and other shellfish.
5. Infected ice.
6. Infected cream, ice cream and various foods.
7. By direct contagion or contact.
8. Through the medium of flies and general uncleanness.
9. Through infected soil areas.

It may be well to explain that typhoid germs, in order to produce disease, must enter the digestive tract. The brunt of the lesion falls upon the small intestine. The inhalation of infected dust, as well as the ingestion of articles of food and drink, is believed to occasionally convey the infection. Be this as it may, certainly here in Maryland the most common vehicle of contagion is an infected drinking-water supply. The well or spring generally becomes contaminated through defective drainage. The surface toilet plays a conspicuous rôle. It is my fond hope, and I am exerting every effort to bring about such a consummation, that three very useful but unsanitary commodities be banished from Maryland:

1. The surface toilet.
2. The public drinking cup.†
3. The common roller towel.

IV. RECORD OF EPIDEMICS.

In those early days the Maryland colonists were forced to combat contagious disease each in his own style. The custodians of the public health—the Baltimore City Health Department, the Medical and Chirurgical Faculty of Maryland and the Maryland State Board of Health—destined to suppress disease and foster the health and happiness of the people, had not yet been created or organized. The first Baltimore city health ordinance was passed in 1750. The Medical and Chirurgical Faculty of Maryland was organized at Annapolis in 1799. The State Board of Health of Maryland was created by legislative enactment in 1874. A provisional Board of Health had been formed prior to this date, and

*Read Prof. William T. Sedgwick's address, "The Call to Public Health," published in *Science* of date August 14, 1908.

†To my knowledge the public drinking cup is already prohibited by law in at least four States—Kansas, Oregon, Louisiana and New Jersey.

in 1866 one of the duties imposed upon it was to prevent epidemics, cholera being prevalent at the time.

EARLY EPIDEMICS.

The first recorded Maryland epidemic of typhoid fever occurred at Port Deposit, Cecil county, in the year 1875. The epidemic developed among persons using water from an infected well. There was a total of 30 cases of sickness, with one death. The first house outbreak of typhoid fever recorded occurred in July of the same year (1875), in the town of Trappe, Talbot county.

The late Dr. John Morris of Baltimore, writing in the year 1876, makes the following statement concerning typhoid fever in the city of Baltimore:

"Among the diseases of a zymotic character due to unsanitary local conditions are, as is well known, diphtheria, typhoid fever and scarlatina, all of which prevail to a very serious extent in Baltimore. One hundred and eighty-four deaths* from typhoid fever alone occurred during the past year (1875), while deaths from the same cause in the city of New York, with a population three times greater, numbered but 200. This is a startling statement when taken in connection with the fact that every case of typhoid fever is due to a local cause, and that that particular cause can, in nearly every instance, be ascertained and prevented if due pains be taken; and further, that as a consequence any case of death from this disease is the result of recklessness or ignorance."

The lapse of 35 years of time has but verified and emphasized the importance of Dr. Morris' statements. In this particular instance, time, the great healer of all wounds, has failed to assuage the irreparable injury done by typhoid fever, and the indignation aroused by its ravages. Instead, the breach has widened. In certain sections of this country it has been intimated that eventually an individual will even go so far as to sue the municipal authorities for damages in every case of typhoid fever traced to pollution of a city's water supply or other articles of food or drink.

The first recorded milk epidemic of typhoid fever occurred in Elkton, Cecil county, in July, August and September, 1884. Five years later an extensive water-borne epidemic of typhoid occurred in Cumberland, the "Queen City of the Mountains." Within the 18 months ending March 17, 1891, a total of 587 cases of typhoid fever, including 52 deaths, occurred within the corporate limits of Cumberland. In July, 1889, an epidemic of typhoid fever appeared in Pikesville, Baltimore county. This epidemic was also traced to polluted drinking water.

The year 1897 was especially fruitful of typhoid fever epidemics. I have procured records of the following six epidemic outbreaks of typhoid fever occurring in that year:

1. In the months of August and September typhoid fever was

*The Baltimore City Health Department records give a total of 187 deaths from typhoid fever in this year (1875).

epidemic at Newark, in Worcester county. This was a water outbreak, which resulted in three deaths.

2. In September there was a localized outbreak of typhoid fever at Poplar Springs, Howard county.

3. About the same time (September) there was an outbreak of typhoid fever—10 cases, with 3 deaths—at Preston, Caroline county.

4. A few days later an outbreak of typhoid fever was reported at Still Pond, Kent county.

5. Early in the same month (September) an outbreak of typhoid fever was reported at Brooklyn, Anne Arundel county.

6. In November and December an outbreak of typhoid fever occurred at Davidsonville, Anne Arundel county.

LATER EPIDEMICS.

In the year 1898 four epidemics of typhoid fever prevailed in Maryland. The first occurred at the House of Reformation for Colored Boys, at Cheltenham, Prince George's county. There were 15 cases of the disease. In the month of October typhoid fever was epidemic (nine cases) at Lord, Allegany county. In November there was an outbreak consisting of four cases of typhoid at Ocean, Allegany county. In late summer and early autumn of the same year (1898) there were 24 cases of typhoid fever in Catonsville district, Baltimore county.

In the summer of 1900 another milk epidemic of typhoid fever occurred in Elkton, Cecil county. There were 59 cases of sickness, with 2 deaths, a mortality of 3.2 per cent.

In July and August, 1904, a well-known water-borne epidemic of typhoid fever occurred in Mt. Savage, Allegany county. There was a total of 115 cases of the disease. In August, 1904, typhoid fever was epidemic at Eastport, Anne Arundel county.

In July and August, 1905, typhoid fever assumed epidemic proportions in the Springfield State Hospital. In August, September and October, 1905, typhoid fever was again epidemic at Port Deposit, Cecil county.

RECENT EPIDEMICS.

In the summer of 1906 the Woodberry-Hampden milk epidemic of typhoid occurred. There were in all 157 cases.

In July and August, 1909, there was a water-borne outbreak of typhoid fever in Chestertown, Kent county, comprising a total of 29 cases.

In 1910 I investigated the following four epidemics of typhoid fever:

1. Bryantown, Charles county, July and August. A total of 11 cases.

2. Salisbury, Wicomico county, August. A total of 40 cases.

3. Arlington-Pimlico, Baltimore county, September and October. A total of 33 cases.

4. Eastport, Anne Arundel county, late summer and early autumn. A total of 35 cases.

In the present year (1911) I have so far investigated five typhoid fever outbreaks:

1. Goldsboro, Caroline county, August. A total of 14 cases.
2. Waldorf, Charles county, September and October. A total of 14 cases.
3. Frostburg, Allegany county, September and October. A total of 28 cases.
4. Maryland House of Correction, Jessup, Anne Arundel county, October and November. A total of 33 cases, with 4 deaths.
5. Worton, Kent county, summer and autumn. A total of 13 cases.

V. ETIOLOGY OF EPIDEMICS: A SUMMARY.

The limitations of time will not permit me to go into detail concerning this list of typhoid fever epidemics. Suffice it to say that the greatest of all epidemics was the water outbreak at Cumberland in 1890, comprising a total of 587 cases.

Next in point of numbers was the milk epidemic of 157 cases, in the Woodberry-Hampden district of Baltimore city.

To sum up the situation, it can be said that polluted drinking water is the principal cause of typhoid fever in Maryland. The Waldorf epidemic and the House of Correction epidemic were spread through the agency of flies. The Frostburg epidemic was due to infected soil—soil against a steep hillside in which typhoid stools had been buried year after year. Only antityphoid vaccination of the residents will prevent the recurrence of a like epidemic in Frostburg.

VI. IS TYPHOID FEVER INCREASING.

We have now arrived at the turn of the road where it is prudent to ask, "Is typhoid fever increasing?" Statistics show that it is not. For the purposes of comparison, the annual death rate from typhoid in Maryland may thus be tabulated for the latest four census years:

TABLE NO. I.

Annual Death Rate from Typhoid in Maryland.

Census Year.	Population.	No. of Deaths.	Death Rate per 10,000.
1880.....	934,943	716	7.66*
1890.....	1,042,390	476	4.57
1900.....	1,188,044	526	4.43
1910.....	1,294,450	544	4.21

The above table shows in a general way the status of typhoid

*These figures are excessive, and doubtless include deaths from typhus fever, "typho-malarial" fever and other hybrid diseases.

fever in Maryland. I am indebted to Dr. Bosley* for the next table, which gives extended figures for the city of Baltimore:

TABLE NO. II.
Typhoid Fever in Baltimore City.

Year.	Estimated Population.	Cases of Sickness.	No. of Deaths.	Death Rate Per 10,000.
1875.....	267,354	....	187	6.99
1876.....	267,354	....	176	6.59
1877.....	311,275	....	211	6.78
1878.....	318,182	....	176	5.53
1879.....	325,139	....	167	5.14
1880.....	332,313	....	196	5.90
1881.....	339,649	....	197	5.80
1882.....	347,142	....	165	4.75
1883.....	354,832	....	126	3.55
1884.....	362,668	....	151	4.16
1885.....	370,696	....	155	4.18
1886.....	378,903	....	150	3.96
1887.....	387,300	....	156	4.03
1888.....	395,899	....	161	4.07
1889.....	404,498	....	191	4.72
1890.....	413,671	....	247	5.97
1891.....	426,917	....	150	3.51
1892.....	440,163	....	193	4.38
1893.....	453,409	....	224	4.90
1894.....	466,655	....	222	4.76
1895.....	479,907	260	173	3.60
1896.....	493,147	472	188	3.81
1897.....	506,398	363	189	3.73
1898.....	541,000	545	189	3.49
1899.....	541,000	462	153	2.08
1900.....	541,000	871	189	3.49
1901.....	518,000	792	141	2.72
1902.....	525,000	1,086	220	4.19
1903.....	533,000	768	189	3.55
1904.....	541,000	916	199	3.68
1905.....	550,000	1,019	197	3.58
1906.....	558,000	1,215	183	3.28
1907.....	565,000	1,417	230	4.07
1908.....	573,000	1,426	180	3.14
1909.....	581,000	1,069	136	2.34
1910.....	589,000	1,891	235	3.99
1911.....	564,545	1,201	154	2.73

The next table (Table III) indicates in a succinct form the prevalence of typhoid fever in the counties of Maryland, exclusive

*Dr. James Bosley, Health Commissioner of the city of Baltimore, 1900—.

of Baltimore city. Table No. I gives statistics for all Maryland; Table No. II gives Baltimore city statistics, and Table No. III, statistics for the counties of Maryland, exclusive of Baltimore city.

TABLE No. III.

Typhoid in the Counties of Maryland.

Year.	Estimated Population.	Cases of Sickness.	No. of Deaths.	Death Rate Per 10,000.
1907.....	733,335	969	295	4.02
1908.....	741,397	1,647	350	4.72
1909.....	749,537	1,977	294	3.92
1910.....	757,767	2,348	309	4.08
1911*.....	742,891	1,980	349	4.70

I am prepared to give some earlier data than those contained in the above table (Table No. III). In the year 1896, the first year in which anything like complete typhoid fever returns were secured, there were reported 1171 cases of typhoid fever, with 218 deaths, in the counties of Maryland. In 1897 there were 1214 cases of typhoid fever reported, with 222 deaths. Combining the two years—1896 and 1897—we obtain a yearly average of 220 deaths from typhoid fever in the counties of Maryland alone. In the city of Baltimore, in 1896, there were 188 deaths from typhoid fever; in 1897, in Baltimore, there were 189 deaths from typhoid. Combining the State and city figures, the total deaths from typhoid fever in the entire State of Maryland in the year 1896 were 406; in 1897, 411 deaths.

VII. PREVENTIVE MEASURES.

An intensely interesting volume could be written on "Typhoid Fever: How to Prevent Its Spread." The chronicler of this all-important subject doubtless would begin with a consideration of the drinking-water supply.

Preventive measures, to be effective in eradicating typhoid fever, must be State wide in their scope. They should be largely educational, and must reach the remotest country districts. As a matter of historical reference I desire to mention several valuable recommendations already given, and which have been tried and found exceedingly useful. The first suggestion was made by a minister of the gospel, the Rt. Rev. Henry C. Lay, Bishop of Easton, Talbot county. It is gratifying to record that ministers of the gospel have always held a prominent place in sanitary science and in pure science, especially ministers of the Episcopal faith. As early as 1876, in Maryland, Bishop Lay recommended the application of dry earth to typhoid stools to prevent the spread of typhoid fever. Bishop Lay's paper, entitled "Dry Earth in Its Sanitary Applica-

*These figures have been revised so as to include 1911 statistics entire.

tions to Farm Houses and Village Dwellings," could be read with advantage by everyone interested in this gigantic problem.*

The State medical society—the Medical and Chirurgical Faculty of Maryland—was not dilatory in grasping the urgent needs of the situation. In the president's address (Prof. Richard McSherry) at the 1884 meeting the following six subjects were mentioned as requiring attention at the time:

1. A sanitary survey of the State, to be carried out under the direction of the State Board of Health.
2. The pollution of streams.
3. The adulteration of food and medicines.
4. The securing of representative and respectable incumbents of medical positions in the service of city and State.
5. The appointment of medical inspectors of schools. And
6. The investigation and restriction of the social evil.

Another epoch was marked in 1888, when Dr. C. W. Chancellor, then secretary to the State Board of Health of Maryland, wrote of "the effect of improved water supplies in diminishing typhoid cases."

When typhoid fever is present in a community it is customary to advocate the boiling of all water used for drinking and domestic purposes, the pasteurization of milk, protection from flies, and avoidance of uncooked fruits and vegetables. Here the old adage, "An ounce of prevention is worth a ton of cure," is applicable, and it is infinitely better sanitation to keep typhoid fever out of a community than to eradicate it after it has once gained a foothold.

VIII. WHAT ARE WE GOING TO DO ABOUT IT?

I have endeavored to present to you a brief account of the annual typhoid situation in Maryland. The problem is a monstrous one, and doubtless has alarmed many of my hearers. At this juncture the question naturally arises, What are we going to do about it?

The solution to this intricate problem depends somewhat, but not wholly, upon the nature of the epidemic. If due to a polluted water supply, boiling or filtering the drinking water should be ordered, or a better drinking water obtained. If the epidemic be milk-borne, pasteurize the milk and adjust conditions on the dairy farm.

Antityphoid vaccination, a perfectly simple procedure, has proven to be of inestimable value. Dr. Clark's experience at the Springfield State Hospital should be convincing.† Of 890 persons vaccinated, not one contracted typhoid fever. Formerly there were on the average 15 cases of typhoid, with 2 deaths, in the Springfield hospital each year. The State Board of Health has recently passed an order requiring all inmates of State institutions to be immunized against typhoid. The United States Department of Agriculture

*See Bishop Lay's paper in the First Biennial Report of the State Board of Health of Maryland, January, 1876.

†Dr. J. Clement Clark, superintendent of the Springfield State Hospital for the Insane, Sykesville, Carroll county, Maryland.

has urged its 13,500 employees to be vaccinated against typhoid fever.

Destruction of flies should be recommended. The following supposed "Journal of a Female House Fly" may prove interesting:

IX. JOURNAL OF A FEMALE HOUSE FLY.

1. Thursday, November 2, 1911. On this day, at 3.05 P. M., the first snow of the season fell. Went into my place of hibernation in a small crevice behind the kitchen mantelpiece.

2. Barely lived through the long, hard winter of 1911-1912. I knew it would be a cold winter, because there were five indications:

- a. The summer of 1911 was an unusually hot one.
- b. The ragweeds grew exceptionally tall.
- c. The corn-husks were very thick.
- d. The squirrels nested low. And
- e. Chestnuts were plentiful.

3. April 15, 1912. Emerged from my place of concealment and laid my first batch of eggs—120 in number. These eggs were laid in a heap of horse manure. Time, 2 P. M.

4. April 16, 1912. Time, 10 A. M. My first 120 eggs have hatched.

5. April 17, 1912. Time, 10 A. M. Larvae have undergone first molt.

6. April 18, 1912. Time, 10 A. M. Larvae have undergone second molt.

7. April 21, 1912. Time, 10 A. M. Larvae transformed into pupae.

8. April 26, 1912. Time, 10 A. M. One hundred and twenty adult flies issue from the pupal state, 60 of which are females.

9. April 27, 1912. Startling news! The Women's Civic League of Baltimore has this day re-inaugurated its campaign against the fly. Last summer (summer of 1911), through the untiring efforts of this League, about 15,000,000 of our family were destroyed! In the language of Cicero, the illustrious orator: "*O tempora! O mores!*" *E pluribus unum!* *Multum in parvo!* *Non compos mentis!* Tweedle-dee and tweedle-dum!

10. April 28, 1912. Time, 2 P. M. Laid my second batch—120 eggs. This time I laid my eggs upon human excrement found in an uncared-for privy.

11. May 8, 1912. Time, 10 A. M. One hundred and twenty flies issue from my second batch of eggs. Laid my third batch of eggs—160 in number—in a kind neighbor's garbage can.

12. May 10, 1912. I have just learned that Dr. L. O. Howard, a famous entomologist over in Washington, has had the audacity to apply to us the opprobrious epithet of "typhoid fly." And to add insult to injury, Dr. Charles Wardell Stiles, he who discovered the American hookworm, has dubbed us the "filth fly."

13. May 12, 1912. We have been attracting considerable attention here of late. Of a truth, our deeds are known of all men.

As a consequence, the city of Baltimore is planning for our total annihilation. Last summer (summer of 1911) the Women's Civic League even persuaded the school children to turn against us and become our enemies. One plucky little fellow, Master Herbert Meier by name, captured and killed 40 quarts of us, winning a prize of \$25. And to think—we were brought up on the same bottle!

14. May 18, 1912. Time, 2 P. M. One hundred and sixty adult flies issue from my third batch of eggs. Left alone and unhindered, by September 10, 1912, my progeny would number 5,598,720,000,000.

15. May 20, 1912. Alas and alack! for the uncertainty of a fly's life. I have had the misfortune to drop into Master Herbert Meier's fly-trap, and my doom is sealed. I have tried to live up to the best that is in me. I know that in the sight of my arch-enemy—Man, I have committed many unpardonable errors and wrongs; but, being a fly, I have been guided by blind instinct only. I hereby bequeath my ability to transmit typhoid fever, infantile diarrhea, dysentery, tuberculosis and other infectious diseases to those of my kind who shall come after me, and my name and fame to those who can get them. This is my dying declaration—my last will and testament.

Moral.—Help the Women's Civic League catch and kill the original pair of flies in April.

It is not inapt, at this juncture, to allude to an analogous source of danger in the spread of typhoid fever. I refer to human typhoid "carriers." It has been determined that about 5 per cent. of patients who have apparently recovered from an attack of typhoid fever become carriers of this disease. These may be classified as follows:

- a. Gall-bladder infections, 3 per cent.
- b. Urinary bladder infections, 2 per cent.

Here in Maryland some seven or eight typhoid "carriers" have been found. In one particular instance, that of Mrs. E. V., a white woman aged 64 years, 22 cases of typhoid fever, with 1 death, were traced to infection from a single bacillus carrier. Mrs. E. V. died of influenza on December 23, 1910. No autopsy was permitted. She had had typhoid fever in 1908. It was a severe attack, and lasted from August 18 to November 7. Typhoid bacilli were recovered from her stool and also from her urine.

X. OTHER MEASURES.

So far the measures which I have advocated for combating typhoid fever have been but tentative. They apply only to each specific instance, and in point of time are available only when the epidemic has already become established.

This is bad generalship. It were better for us to change our tactics and concentrate our forces upon those things which are liable to precipitate an epidemic. Instead of having a "clean-up day" after typhoid fever has invaded a community, it should be insisted upon beforehand.

These means to an end may be attained in several ways. The municipal leagues and civic betterment and social clubs are "fighting the good fight of faith" for improved sanitation in a very commendable manner. Down in Louisiana Dr. Döwling has met these conditions by touring the State with what may be termed a "health train." The president of the Medical and Chirurgical Faculty sounded the keynote in 1884, when he recommended that a sanitary survey of the State should be made. At the semi-annual meeting of the Medical and Chirurgical Faculty, held at Annapolis September 12, 13 and 14, 1910, I advocated the formation of a "Health of Towns Commission," to be modeled after the English "Health of Towns Commission." The English "Health of Towns Commission," the pioneer body of its kind, did much for public health advancement, and its methods have been widely copied.

Here in Maryland, however, the State's annual typhoid problem can be met and conquered in a still better way. It consists in organizing a Bureau of Sanitary Engineering in the State Department of Health. This bureau was not organized in 1910, because the available funds were insufficient. The following were to be the chief functions of the Bureau of Sanitary Engineering:

1. The making of sanitary surveys of cities and towns.
2. Inspection of public and private water supplies.
3. The consideration of problems of sewerage and drainage.

At the present time there are a few good, clean towns in Maryland, but the majority are in urgent need of sanitary supervision. Inspection and renovation should be done before an epidemic appears; in other words, epidemics should be prevented rather than suppressed. As examples of clean towns I might mention Denton, Caroline county; La Plata, Charles county, and Boonsboro, Washington county. In 1910 there were 11 cases of typhoid fever in La Plata. The town had a "clean-up" day. As a consequence, in 1911 there has been but one case of typhoid fever in La Plata, and that was an imported case.

In Baltimore city the annual typhoid problem bids fair to be soon gracefully met. At the present time Baltimore ranks high—second only to Milwaukee—as a typhoid city. With its new sewerage system, one of the modern wonders of the sanitary world, and its purified water supply, Baltimore's death rate from typhoid should fall as low as any in this country.

In the rural districts the problem presents greater obstacles. The city of Baltimore covers but 32 square miles of territory; the counties of Maryland, 9828 square miles. The county people are remote from municipal leagues, civic clubs and similar organizations which are doing so much for physical and moral betterment in our cities and towns. Unfortunately, the country place is looked upon, and rightly, as the stronghold of typhoid fever. Dr. Freeman of Virginia recently published a very suggestive paper along these lines. Dr. Allen W. Freeman's paper is entitled "The Farm; the Next

Point of Attack in Sanitary Progress." Table No. IV, giving comparative statistics for the year 1911, is interesting.

TABLE NO. IV.

*Maryland Typhoid Fever Statistics, 1911.**

	Jurisdiction—		Total.
	City of Baltimore.	Rural Maryland.†	
January—			
Number of cases.....	55	73	128
Number of deaths.....	11	19	30
February—			
Number of cases.....	31	56	87
Number of deaths.....	3	13	16
March—			
Number of cases.....	35	44	79
Number of deaths.....	5	20	25
April—			
Number of cases.....	44	39	83
Number of deaths.....	8	11	19
May—			
Number of cases.....	56	44	100
Number of deaths.....	7	17	24
June—			
Number of cases.....	34	65	99
Number of deaths.....	8	11	19
July—			
Number of cases.....	89	163	252
Number of deaths.....	4	18	22
August—			
Number of cases.....	280	347	627
Number of deaths.....	22	47	69
September—			
Number of cases.....	241	436	677
Number of deaths.....	31	59	90
October—			
Number of cases.....	170	332	502
Number of deaths.....	28	51	79
November—			
Number of cases.....	104	206	310
Number of deaths.....	19	52	71
December—			
Number of cases.....	62	175	237
Number of deaths.....	8	31	39
Total—City of Baltimore, year of 1911—			
Cases of typhoid fever.....			1201
Deaths from typhoid.....			154
Rural Maryland, year of 1911—			
Cases of typhoid fever.....			1980
Deaths from typhoid.....			349
Grand Total—Entire State of Maryland, 1911—			
Cases of typhoid fever.....			3181
Deaths from typhoid.....			503

*Revised so as to include the entire year of 1911.

†The entire State of Maryland, exclusive of Baltimore city.

XI. ECONOMIC LOSS DUE TO TYPHOID.

Typhoid fever exacts from the people of Maryland an annual toll of \$2,000,000, to say nothing of the sickness and suffering which it causes. These figures, however, are only approximately correct, and are based on the following computation:

Financial value of an adult human life.....	\$5,000
Cost of sickness, each case of typhoid.....	200.
Funeral expenses in fatal cases.....	100

According to those figures, each fatal case of typhoid fever means an economic loss to a community of \$5300. In regard to children, the calculation is usually based on the proposition that it costs \$1800 to rear a child from infancy to the age of usefulness.

Doubtless the above figures appear startling, but they have a pretty sound financial basis. This becomes more apparent when I remind you that the death rate from typhoid fever in Baltimore city in 1910 was 3.94 per 10,000 of the population.* In the counties of Maryland, exclusive of Baltimore city, the death rate from typhoid fever in the year 1910 was 4.08 per 10,000.

XII. RECOMMENDATIONS AND CONCLUSIONS.

These must necessarily be brief, and can be summarized as follows:

1. Typhoid fever is decreasing in Maryland, both as regards prevalence and virulence. To be more explicit, there are fewer cases of typhoid fever per 10,000 of the combined population than formerly, and the disease is usually of a milder type.

2. Some of the figures which I have given may belie the foregoing statement. Two things should be taken into consideration: The population of Maryland is steadily increasing, and formerly not more than one-half of the typhoid fever cases were reported.

3. The only practical solution to Maryland's annual typhoid problem rests on the formation of a Bureau of Sanitary Engineering in the State Department of Health.

- 4th and lastly. As our brethren of the legal profession would say, I have three short prayers to make:

- a. That you will aid in getting an increased appropriation for the State Department of Health when the Legislature meets in January, 1912, so that the Bureau of Sanitary Engineering may be established.

- b. That you will aid and encourage the various municipal leagues and civic clubs throughout the State in the good work they are doing towards physical, moral and civic betterment.

- c. That you will advocate a "clean-up" day for all the cities, towns, villages, communities and country homes throughout the great and progressive State of Maryland.

*The Census Bureau gives a death rate of 3.99 per 10,000. This disparity is due to a slightly different figure having been used for the estimated population.

IS SYPHILIS HEREDITARY?

By E. Kilbourne Tullidge,

Baltimore, Md.

To discuss syphilis as a hereditary disease we must first define disease, which, according to McFarland, "is the inharmonious relation of the individual to his environment," and second, obtain a clear, distinct idea of the term hereditary.

In the true biological sense this term is much misused in medicine and surgery, being applied to many pre-natal conditions that have nothing to do with it. In biology the term "hereditary" is used to describe conditions transferred from parent to offspring by peculiarities of the germ plasm. It does not refer to accidental conditions of pre-natal life by which the health or perfection of the offspring is affected. These conditions are termed "congenital."

Many of the present day biologists differ as to whether acquired characteristics can be transmitted to the offspring or not. If not, then there can be no such thing as a hereditary disease or deformity. Lamarck and Darwin believed firmly in inheritance and in the transmission of acquired characteristics; Darwin making it the basis of his theory of evolution.

Weissmann, Francis Galton, Adami, and perhaps the majority of the present day biologists, doubt or disbelieve its possibility. It seems certain that experimental characteristics; i. e., mutilations such as result from circumcision, amputations, nucleations, scoliotomy, etc., are not transmitted, but it appears certain that spontaneously acquired variations from the normal may be transmitted. Adami has suggested that heredity may be explained upon the assumption that the idioplasm, or that part of the protoplasm possessing vital properties, is composed of a mass of molecules which form a central ring, to which side rings may be attached, or from which they may be detached without alteration of the central primitive ring. Environment causes the central ring to have attached certain side chain combinations, and in this way the modifications of the tissue cells are consummated. In the same way environmental conditions lead to further modifications in the forms of new lateral chain combinations. Those lateral chains that are last developed are the least stable and the most readily lost, while those which have been attached for a long period of time are not readily loosened. Thus it is that conditions produced by the lateral chains which have been active for generations tend to persist, while those recent changes in structure or alterations of environment produce with the general idioplasm combinations too weak to be transmitted.

The hereditary conditions thus far considered refer to immediate peculiarities, as the possession by the parent of a peculiarly situated lock of white hair, which peculiarity is transmitted to

the child, or the parent has six fingers or toes, which also appear in the offspring.

In connection with certain diseases, hereditary conditions are however, more remote, thus in hæmophilia, or "Bleeders disease," we find a certain mode of transmission. The male suffering from the conditions may not transmit it to his immediate offspring, though his daughters are very apt to transmit it to their sons, thus skipping a generation.

Consanguinity is a dangerous hereditary condition from its tendency to accentuate family weakness. This danger being in proportion to the deviations from normal of those concerned.

Atavism is another peculiarity in which the traits of remote ancestors may make their appearance, such as flat-foot, receding forehead, prognathism, or protrusion of the lower jaw, and massive projecting ears, all characteristics of the lower animals and Simian race.

Many pathologists divide the subject of heredity into two divisions; namely, true heredity, or that condition just discussed; and false or apparent heredity, commonly mistaken for heredity proper, and to which are accredited those modifications of the embryo by conditions occurring in pre-natal life. Thus certain infectious diseases, such as smallpox and syphilis, may be transferred from mother to fœtus through the placental circulation and cause the disease acquired from the parent.

Those pre-dispositions or tendencies which occur in the offsprings of tuberculous, cancerous and neurasthenic subjects may depend upon transmitted physiologic peculiarities, or may be nothing more than the result of lack of vigor of the germ plasm, whose development results in a feeble individual.

Human ova are free, or almost free, from yolk, and are relatively very small. There has not been a single observation, according to Adami, showing that the mammalian ova is phagocytic; i. e., able to take up foreign particles. That minute spermatazoa should act as carriers is still more unlikely, and the possibility that they do so has been negated by Gärtner.

Adami has shown that the minimum number of tubercle bacilli that will set up peritoneal infection in the guinea pig is eight; in the rabbit 24 to 30, and Gärtner, after obtaining the seminal ejaculations from tuberculous guinea pigs, found that only five out of thirty ejaculations contained a sufficient number of bacilli to cause the disease. Rohlff did not once succeed in rendering rabbits tuberculous by injecting them with semen of men suffering with phthisis. Gärtner concludes that the semen emitted by a phthisical patient does not on the average contain as many as ten bacilli.

From these experiments of Rohlff and Gärtner, Adami calculates that on the average, human seminal ejaculations contain more than 226,000,000 spermatazoa, and if the semen contained not ten, but 1000 spirochetes, the chances that an individual

spermatozoon fertilizing the ovum should bear with it a spirochete and so lead to germinal infection are as one is to 226,000. If 1,000,000, ratio would be 1.226, only one out of 85,000,000,000 spermatozoa having a chance of fertilizing an ovum. One may draw his own conclusions as to the chance of a spermatozoon conveying the disease from father to the offspring. It is so absurdly minute as to be almost nil.

That cases of syphilis in the new-born are most often of late intra-uterine acquirement is made evident by Chiari, who states that in 90% of infants presenting signs of syphilis, the liver is the seat of the most syphilitic disturbances. Infection through the placenta amply explains the conditions in infants, for practically all the blood on its way through the placenta passes through the liver, which is thus the organ first subjected to infection. Adami specifically states that whenever there are active and specific manifestations of tuberculosis, syphilis or other infective diseases of the new-born child, the condition is of intra-uterine acquirement, and not inherited. This statement he supports by referring to the various stages to which one may find the disease developed in the new-born.

After an interesting series of observations of experiments on healthy does, Freichmann concluded that bacilli introduced into the uterus outside of the amnion may some days later be found in the amniotic fluid, whether through the placenta (from maternal affection), through the wall of the foetal sac, or by passage into the developing ovum before that sac has developed, organisms may infect the embryo. These various means are adequate to explain the phenomenon without calling upon improbable infection of the ovum or spermatozoon prior to fertilization.

Children of syphilitic or tuberculous parentage who exhibit certain stigma as foetal cachexia, malnutrition, senile expression, senescence, even malformations, are those who have acquired these characteristics presumably by the germ plasm presenting modifications and disturbances peculiar to the parental germ cell.

After weighing the many arguments upon the passage of foreign substances through the placenta advanced by Bonnett, Hofbauer, Wallgren, Polano, Schmidlechner, Liebauch, and others who have experimentally proven the transmission of iron, fat, albumosis, toxins of diphtheria and tetanus, the organisms of pneumonia, relapsing fever, various infections due to pyogenic organisms and typhoid fever, which of the many mentioned is most frequently transmitted, due no doubt to its motility, it is apparent that the functions of the placenta are not limited to mere absorption by osmosis. The adverse condition, namely the transmission of materials from the foetus to the mother has been demonstrated by Savoy and Guserow. Therefore, we may safely say that it seems hardly probable that infection of the foetus may occur without some transmission of the organisms, or their toxins, to the mother, and vice versa.

The reason why the manifestations are not apparent at the time of delivery is due probably to a latent stage or period in which the spirochete develops a provisional immunity only to be followed by manifestations of the disease in later life.

Keyes states, after citing "Colles's law," that the mother of such a syphilitic child (Colles's Child), although herself remaining healthy many years, almost invariably ultimately breaks out with tertiary syphilis (*choc en retour*), and that therefore the mother of a syphilitic child, even though she remain apparently sound, is syphilitic.

In conclusion, let us suppose that should a father transmit the disease apparently only to the fœtus by the fertilization of an ovum by a spermatazoon conveying a spirochete, and to which spermatazoon has been given its one 85,000,000,000 of a chance, according to Adami, and should this one spirochete be sufficient in itself to produce the disease, which is highly improbable and unlikely, the infection would not be confined to the embryo, but would involve the placenta as well, and from there be transmitted to the mother. The condition would be a disease not the result of peculiarities of the germ plasm, but the result of an exogenous or mechanical infection, which we must admit in the true biological sense is only congenital.

The explanation for the erroneous use of the word "hereditary" in connection with this disease by the profession is, probably, due to the only recent acknowledged definition of the term.

PRACTICAL ELECTRO-THERAPEUTICS AND X-RAY THERAPY. With Chapters on Photo-Therapy, X-Ray in Eye Surgery, X-Ray in Dentistry, and Medico-Legal Aspect of the X-Ray. By J. M. Martin, M.D., Professor of Electro-Therapeutics and X-Ray Methods in the Medical Department of Baylor University, in the Medical Department of Southwestern University, and in the State Dental College, Dallas, Texas; Member of the Texas State Medical Association, American Medical Association, American Roentgen X-Ray Society, etc. 219 illustrations. St. Louis: C. V. Mosby Company. 1912.

This book is written in such a strain as to give the student a complete insight into the principles or essentials of electro-therapeutics, the use of the X-ray and high frequency apparatus. To date too little attention has been paid by medical schools to these agents, and the student leaves college without practical insight into what such forces can or cannot be expected to do. We realize that the time allotted to a student to train for his doctorate is too short, but be this as it may, there is no excuse for students leaving college without any instruction at all in electricity as applied to medicine. This book should go a great way toward correcting this evil. It is short, comprehensive and embraces the underlying principles of the subject.

Book Reviews.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Surgery, Treatment, Medicine, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of William Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; Charles H. Mayo, M.D., Rochester; Thomas H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harrold, M.D., London; Richard Kretz, M.D., Vienna, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume IV, twenty-first series. Philadelphia and London: J. B. Lippincott Company. Cloth, \$2 net. 1911.

Today medical literature is accumulating so fast that it is extremely difficult for the busy practitioner to intelligently select that which is best and of proven utility. As a matter of fact, unless one is acquainted with the integrity of the writer it is in most instances a waste of time to wade through journals. In order to place before the profession articles which can be absolutely relied upon, and to collect the latest and best medical thought in succinct, concrete form, Lippincott, in this volume, as in previous issues, has collected together in book form a series of articles which should meet the most exacting demands of the profession.

No condition gives the physician more worry and perhaps worse results than enuresis. In many instances no matter what is done for the patient it is of no avail. After a careful reading of the article by Dr. James Burnet of Edinburgh on this subject, one is forcibly impressed with the number of affections which might be the etiologic factor. He claims that enuresis is most frequently met with in nervous children, and that in a large number of cases definite changes in the urine will be found, although in the great majority a slight degree of hyperacidity alone exists. Rectal factors should always be kept in view, while adenoids and enlarged tonsils should never be regarded as the cause. Enuresis is frequently an after-effect of prolonged sickness, especially after one of the infectious diseases. In one of Dr. Burnet's cases an undescended testicle seemed to be the only factor. If the patient complains on passing water and has diurnal as well as nocturnal incontinence, a local cause is almost certainly at work, such as tight prepuce, cystitis or a urinary calculus. Pin and round worms are important

etiologically in this connection. An adherent clitoris may cause enuresis. If there is increased frequency of micturition along with enuresis, the existence of diabetes mellitus or of chronic nephritis should be thought of. Besides the above symptoms, the author includes quite a number of other causes as the possible etiologic factor in involuntary wetting.

If the urine is acid and cloudy, the writer finds the following combination very useful: Potassi citras and sodii salicylas, aa 0.5 gramme, three or four times a day. He states in the nervous cases tonic treatment is the best. Cystitis, urinary calculus, pyelitis, vulvovaginitis, urethral polypus, anal fissure, rectal polypus and worms demand appropriate treatment, while a tight prepuce or preputial adhesions may require removal or separation. The author believes it extremely imprudent to suggest removal of tonsils or adenoids as a curative agent in this malady, and he also emphasized the importance of a guarded prognosis when circumcision is recommended. He looks upon drug treatment as of secondary importance. When used, the best result will be obtained from strychnine, either alone or in combination with atropine.

Although nothing new or startling is brought forth in the paper, still the present status of the subject is thoroughly and calmly discussed, and in a few pages one is made acquainted with the essential features of this annoying malady.

Those interested in syphilography will find much of interest in Dr. William B. Trimble's article on "The Modern Treatment of Syphilis." He says, regardless of any revulsion of thought that may follow, there does not seem to be any doubt that the new drug, arsenobenzol, is a very potent remedy, and will find a fixed place in the therapeutics of hues. This, with mercury and the iodides, are the bulwarks in the treatment of syphilis. He claims that it is necessary to employ more than one injection of "606" if used alone, as it has been definitely proven that Ehrlich's original idea that one dose would cure is now a forlorn hope. In the course of the article he states one of the objects of his paper is to speak comparatively of the two drugs, "606" and mercury, and to record some observations made while working with the new drug. He notes that it has been definitely proven that "606" will cause mucous membrane lesions to vanish like magic; that it will cause initial lesions to heal more rapidly than any method we have heretofore had at our command. He is struck with the rapidity with which this agent causes the disappearance of the spirocheta. In some instances they have disappeared in three days. In the experience of the author one injection of "606" is not always sufficient to cause the disappearance of the Wasserman reaction. Therefore, it can be seen that whatever "606" will do, mercury will also, but much less rapidly, and the only benefit to be derived from the new preparation is its quickness of action, which the author hopes will enable us to greatly shorten the period of treatment.

Those interested in modern diagnostic methods in cardiovas-

cular diseases will find in George William Norris' article on the "Modern Instruments of Precision in the Study of Cardiovascular Disease" a complete and brief résumé of the various instruments for taking blood pressure, both arterial and venous, and instruments for recording pulse tracings. The technic in using these instruments is thoroughly described, and the article is amplified with illustrations.

In writing on the Benzidene test for occult blood in the stool, J. Russell Verbrycke, Jr., states that it is not performed as often as it should be. He bases this on the fact that the general examination of feces under the best of circumstances is not pleasant, and is, moreover, difficult for one who has not had considerable experience. The method which he employs, according to the author, is devoid of any great amount of unpleasantness, particularly the part devoted to the Benzidene test. His technic is as follows: The stool to be examined is brought to the office in a closed, airtight fruit jar. The general character of the movement can be noted by looking through the jar. He then opens the jar and takes out a portion of the stool, about the size of a hazelnut, by means of a long spoon curette, and immediately recloses the jar. The feces is mixed in a small glass mortar with 30 c.c. of water. If the movement is fluid, a small amount is poured into the mortar, the feces and water then being well mixed to form a thin dilution about the consistency of thin soup. The reagent is prepared in this wise: Pour into a chemically-clean test tube 12 to 15 drops of a saturated solution of benzidene in chemically-pure glacial acetic acid. Warming the solution causes the benzidene to dissolve more rapidly, and does not interfere with the test. To the benzidene solution add 5 c.c. of dioxygen. After shaking allow to stand for a minute, to see that no impurities are present to turn it blue, then add 4 or 5 drops of fecal extract. A green or blue color denotes a positive reaction. In case a positive test is obtained, the patient is then placed on a meat-free diet for a couple of days and the test repeated. The author, however, claims this is unnecessary, as he has not found the ordinary amount of meat as eaten in the regular dietary sufficient to produce positive reaction. He concludes: "The benzidene test as here performed is simple and not disagreeable. In a considerable number of patients it will not be found necessary to confine them to a lacto-vegetarian diet. It is safer to control a positive reaction obtained with the patient on regular diet by a second test after two or three days of a meat-free diet. The test is of great value in the diagnosis of ulcer and cancer, and of prognostic value in the treatment of the former."

The remainder of the volume is made up of articles of the same high merit as those which we have abstracted, but space forbids any further discussion. Suffice it to say the present volume of "International Clinics" is on the same high plane as its predecessors.

A HANDBOOK OF PRACTICAL TREATMENT. By Many Writers. In three volumes. By 82 eminent specialists. Edited by John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania; and A. O. J. Kelly, M.D., Late Assistant Professor of Medicine, University of Pennsylvania. Volume III. Octavo of 1095 pages, illustrated. Philadelphia and London: W. B. Saunders Company. 1912. Per volume: Cloth, \$6.00 net; Half Morocco, \$7.50 net. Baltimore: The Medical Standard Book Company. 1912.

The third and last volume of Practical Treatment deals with constitutional diseases, diseases of the respiratory system, diseases of the digestive system, the urinary system, the nervous system, the muscles and the mind. Amongst those contributing are such well-known authorities as Theodore C. Janeway, Thomas B. Fitcher, Albion Walter Hewlett, Joel E. Goldthwait, Henry Jackson, John H. Musser, Chevalier Jackson, Charles H. Mayo, William J. Mayo, John G. Clark, Roswell Park, F. X. Dercum. While it is impossible in a work of this kind to include everything in treatment, still the contributions selected justify the statement that the meat of modern treatment has been included in this volume as well as in its associates. Herein can be found fairly fulsome descriptions of the diseases coming under the systems enumerated above; a redeeming feature of which is the fact that surgical conditions are treated by surgeons and not internists, the reader thereby obtaining from recognized authorities in medicine and surgery, under one cover, the proper treatment to be instituted in any given case. Those conditions demanding a rather lengthy description of the treatment, we are pleased to state, are not slurred over, the minutest details being accurately set forth.

DISEASES OF THE SKIN AND THE ERUPTIVE FEVERS. By J. Frank Schamberg, A.B., M.D., Professor of Dermatology and Infectious Eruptive Diseases in the Philadelphia Polyclinic and College for Graduates in Medicine; Diagnostician to the Bureau of Health and Consulting Physician to the Municipal Hospital of Philadelphia; Fellow of the College of Physicians of Philadelphia; Member of the American Dermatological Association. Second edition, revised. Octavo of 573 pages, with 235 illustrations. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1910. Cloth, \$3.00 net.

What the physician wants is a practical book. This he has in the present volume of "Diseases of the Skin and Eruptive Diseases," by Schamberg, though it is not as large as some of its competitors. The illustrations are good and instructive, and the contents not so discursive as to become wearisome. If you have some obscure skin disease under observation, this book will be found of great help in aiding a proper diagnosis. Treatment.—

The treatment of the various maladies to which the skin is heir is full and comprehensive. It is, however, best adapted as a student's manual, to our way of thinking. For this purpose it will be found sufficient to meet the fullest expectations of the most exacting teacher.

MINOR AND EMERGENCY SURGERY. By Walter T. Dannreuther, M.D., Surgeon to St. Elizabeth's Hospital and to St. Bartholomew's Clinic, New York City; Ex-House Physician and Surgeon, Jersey City Hospital, etc. 12mo volume of 226 pages. Illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1911. Cloth, \$1.25 net.

If every new interne were possessed of this little book, he would be better qualified to undertake his duties. It is a common fault of all of us to look upon some procedures in surgery as commonplace and so simple as to be familiar to the embryo. Such is not the case, however, and the novice approaches in most instances a phlebotomy with a great deal of fear and trepidation. There are many other procedures in minor surgery which the larger textbooks skim over as too insignificant to notice. It is just these little details that most of us have had to acquire by hard knocks. Therefore, a book of the above character ought to go a long way toward filling this need of the interne, for here is set forth just what and how to do it in certain emergencies.

CLINICAL DIAGNOSIS. A Manual of Laboratory Methods. By James Campbell Todd, Ph.B., M.D., Professor of Pathology, University of Colorado. Second Edition, revised and enlarged. Illustrated with 164 tinted and non-tinted engravings. 12mo. of 469 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Cloth, \$2.25 net. 1912.

As heretofore students and members of the profession desiring a book of this nature will find Todd's second edition the same reliable book as of yore. The additions have improved the work markedly and have materially added to its scope, though it will still be found the same concise laboratory manual. Among the additions may be mentioned: photomicrography with simple apparatus; the antiformin method for tubercle bacilli; detection and significance of albumin in the sputum; Tsuchiya's modification of Esbach's test; the formalin test for ammonia, and Benedict's methods for sugar in the urine; Wright and Kinnicutt's method of counting blood-platelets; the Wasserman reaction. Much new material has been added to the chapter on animal parasites, and a chapter included on the Preparation and Use of Vaccines. We take great pleasure in commending this volume to those engaged in the medical profession.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, MARCH, 1912

IS A CHILD WORTH AS MUCH AS A HOG?

Well worth the earnest attention of our best alienists is that peculiar process of reasoning by which the father, upon becoming a legislator, devotes his energies to the increasing of the State's revenues, but entirely forgets the right of the child. The particular phobia besetting members of the Legislature when questions of child labor are raised is not confined to the State of Maryland alone. Spasmodically, it is true, the lawmaker recollects that the child of today is the parent of tomorrow, and a protective law goes through. But, usually it is ignored, or the loopholes by which it may be evaded are so numerous that it is ineffective.

With the advent of machinery it was thought that the millennium was near at hand. With manual labor reduced to a minimum the public confidently expected that life would be lighter, easier and healthier. But contrary to expectations, machinery, while undoubtedly the greatest civilizing agent in the world's history, has added to, rather than decreased the misery of the laboring classes. It was soon found that a child could be taught to swing the levers which controlled the action of a machine, therefore a child was employed at lower wages than those demanded by an adult, and the same amount of work ground out. It soon became apparent that the younger the child the less the wage, and the greater the profit to the employer, and the result—little boys

and girls of extremely tender age, in some instances the worker being under ten years of age—were employed. If the years of playtime were taken from the child, and he were paid a wage which would enable him later to gain the education necessary to comfortable living, the system might be condoned, but under existing conditions the little benighted creatures are often paid \$2 a week and less, and are often forced to work fourteen to fifteen hours a day in order to squeeze the last drop of productiveness from him, and are therefore unable to lay aside anything for their future betterment. The heathen in Africa, although he gives his boy hot iron to hold in order to harden his palms, lets him run most of the day to develop his limbs and body; the coal miner of America sets his boy, all but just from the cradle, on a little black seat all day long, where he must keep his eyes glued to the long shutes down which the coal glides, and pick out each piece of slate he sees. All day long in a dark, gloomy, dirty room, the air heavy with the coal dust, nothing around him but long shutes and other boys like himself, too occupied to talk, the little backs bowed over, nothing to think about but the coal before him; too tired at night to do anything but sleep the minute his supper is over, and this unceasing grind, day in and day out—and the members of his State Legislature cannot see why he does not grow up an enlightened man, a credit to the community, when schools are free and they have passed bills for appropriations for playgrounds the child never sees, and parks whereof he knows nothing. While perhaps the work in which children are engaged in States where there are no coal mines is cleaner, it is surely no more elevating, no more healthy, and no less dwarfing to mind, and soul and body. On Sundays the child gets out and sees richer people enjoying themselves, and unconsciously, the first seeds of anarchy are sown in his mind, ready to spring forth when he reaches maturity and talks with boys raised under similar conditions and equally discontented with life. Meantime the legislators wrangle eloquently over such questions as “what constitutes a Democrat.”

Sooner or later the people of this State must awaken to the fact that a child has rights, and that those rights are not being recognized. The well-to-do parent will see that there are thousands who know nothing of the comforts he has been able to bestow upon his own little ones, and the comparison will awaken his sympathies and energies for the comfort of those who have no one to fight their battles. "The children want to work, they want the money"—it's true, but what child would not love to have the moon to play with if it could get it, and what parent does not have to refuse the child something in order to protect its body from physical injury—yet there are children who have no one to protect them. These little children—the parents of tomorrow—dwarfed today, stunted in mind and body—what will their progeny be? Long hours of labor; childish play unknown; sullenness, discontent and rebellion born of an undefined sensation of injustice—these will be instilled into the child with which tomorrow must reckon.

Stringent laws are enacted to keep the San Jose scale from our apple trees; the most ignorant farmer in the State may receive explicit instructions from the State Department of Agriculture concerning the sort of crop best for his land, and if his hog is ill, the State rushes advice to him lest the hog die; but a hog is a hog, whereas a child is only a child.

This question of child employment is a burning one in every State of the union. The law of Maryland exempts this class and that class until there are hardly any classes to which it does apply. The ultimate fate of the State is wrapped in its proper solution. No nation can survive if its inhabitants are weaklings, and if for no other reason than pride in our national fate the influential people—most especially the physician who hourly and daily sees the evils of the present state of affairs—should spare no effort in forcing the legislative bodies of this country to enact competent laws looking to the protection of the child.

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CARDIOPATHIES COMPLICATING PREGNANCY AND LABOR.*

By A. Samuels, M.D.

IN order to be able to give a relative prognosis and to treat and manage pregnant patients with cardiopathies, it is quite necessary to study (1) the effect of normal pregnancy upon the normal heart; (2) the effect of dystocia upon the normal heart; (3) the effect of pregnancy and labor on the diseased heart; (4) the effect of cardiac disease on pregnancy; (5) the consideration of the question of inducing premature labor in patients with heart disease; (6) the management of labor; (7) the problem of matrimony for sufferers of a heart lesion.

In normal labor there is an increase in the size of the heart. This hypertrophy is the result of a prolonged increase in work, which is probably due in part to the dilatation of the heart, and in part only suggested by the increased area of dullness, resulting from the change in the position of the heart. This change in the position of the heart is caused by the growing uterus gradually pushing the diaphragm upward, causing the heart to assume a more transverse position. The apex is not infrequently found in the fourth interspace. James MacKenzie has shown that the dilatation during pregnancy affects the right heart more particularly, and that in very many cases even of otherwise normal women a definite insufficiency of the tricuspid valve may appear, disappear and reappear, and the presence of this insufficiency is shown by the positive venous pulse and the systolic murmur in the tricuspid area. This probably accounts for the appearance of accidental, non-organic murmurs during pregnancy. Various theories have been offered in explanation of this phenomena. The latest theory is that the murmur is caused by a slight kinking of the large vessels, especially the pulmonary artery, as a result of the peculiar dislocation of the heart during pregnancy. It is obvious that special care must be taken in the differentiation of

*Read before the Gynecological and Obstetrical Section of the Baltimore City Medical Society.

this accidental murmur from one produced by a mitral insufficiency.

II. THE EFFECT OF DYSTOCIA UPON THE NORMAL HEART.

With the introduction of reliable and practical instruments for measuring the blood pressure, great interest has been awakened in the question of the effect of a pathological pregnancy upon the cardiac function. As stated before, the blood pressure in a normal pregnancy and a normal heart was found to be between 118 and 126. In cases of eclampsia, the blood pressure may vary anywhere between 130 and 320. In patients with impending eclampsia, the blood pressure increases markedly, and falls after delivery, when the symptoms subside. In very grave and fatal cases there is an extreme increase in pressure. In edema particularly, the pressure seems definitely related to the type of the case; therefore, its observation is of value in prognosis and treatment. In cases of chronic nephritis, with symptoms of toxemia, the blood pressure remains very high, even after the symptoms have been relieved by delivery.

III. THE EFFECT OF PREGNANCY AND LABOR ON THE DISEASED HEART.

The older writers have no doubt exaggerated the dangers of pregnancy and labor upon the diseased heart. Cardiac disease at one time was looked upon as one of the most serious complications of pregnancy, and many eminent physicians claimed that about 40 per cent. of women with serious heart lesions met their death in connection with child birth. While it is extremely difficult to arrive at any definite figures as to the mortality, since Fellner at Schauta's Clinic claims that a heart lesion is not recognized in more than about 14 per cent. of patients, and that in 86 per cent. of these patients suffering with cardiac complication to pregnancy it is overlooked because the cardiac symptoms do not become manifest, I have had 2 deaths in 12 cases, one of these occurring immediately at the termination of labor, and the other three weeks afterwards. If possible, it is rather important that all patients should be thoroughly examined, in order that the cardiac complication may be detected, for more reasons than one—firstly, operative methods may become necessary to quickly terminate labor to prevent a fatality, and secondly, since the introduction of the Momburg belt constriction, the application of the belt is strictly contraindicated in the presence of any form of heart disease.

During pregnancy minor cardiac lesions are rather difficult to detect. Early signs of break in compensation may also be difficult to detect, since there is a change in the position of the heart, changes in the area of dullness, changes in the pulse rate, blood pressure and frequently accidental murmurs, or even physiological relative tricuspid insufficiency of muscular origin. Edema of the lower extremities and of the genitalia may be caused solely by the pressure of the heavy uterus against the pelvic veins. The

diagnosis of a decompensation during pregnancy depends, however, upon signs that are relative rather than absolute. Dyspnea and cyanosis on very slight exertion, such as quietly walking a few hundred yards, walking up a few stairs, the presence of a small, rapid pulse, persistent cough, enlargement of the liver and edema of the legs may be regarded as the most important symptoms. It may also be said, the earlier in pregnancy these symptoms occur, the more alarming they are. Statistics of the fatalities to mother and child are valueless, some authorities claiming an overwhelmingly high mortality to both mother and baby, while others place the mortality ridiculously low. I think we must all bear in mind that cardiac lesions are all more or less dangerous, and the successful outcome of both mother and child does not depend so much upon the lesion present, but to the condition of the myocardium. Valvular lesions seem to be the least dangerous; stenosis, mitral stenosis and chronic myocarditis, due to infection or intoxication, the most dangerous. The most serious consequences have been noted in first labors. This is explained probably by the difference in duration and the severity. For patients who have had several breaks in compensation during their pregnancy, without the proper rest and care, prognosis is distinctly grave, both to the mother and child.

The greatest dangers arising from cardiopathies in pregnancy are degenerative changes in the myocardium. It must be borne in mind that heart failure is essentially a question of the integrity of the heart muscle, and this I should like to impress upon you, as in the treatment of the various forms of cardiac failure it is the integrity of the cardiac muscle which we have in every case to consider. While in the great majority of cardiopathies a valvular lesion is only an embarrassment to the heart in its work, and one which may be easily overcome, the presence of a lesion, however, is important in that it calls attention to the heart, and may remind us that the disease which has injured the valve may also have injured the muscle. Our object first is always to find out in these patients the extent of the lesion to the muscle, and how far the valvular lesion involves the muscle. In valvular lesions with little or no enlargement of the heart and a fair response to increased force, pregnancy and labor may be without terrors. If response is limited, if palpitation is readily induced by exercise, opinion should be suspended until the result of treatment is ascertained. If the condition is not improved, then the outlook is not so hopeful. It must be kept in mind, however, that some persons with valvular lesions may suffer from most severe heart failure and make good recoveries; in fact, I have in mind one of my patients who has had five children, and who has had at least 10 or 12 attacks of heart failure. During her last pregnancy she had a most severe attack of decompensation two weeks before the baby was born, yet she made an uneventful recovery, and is still living.

Mitral stenosis is more dangerous than mitral insufficiency; at

least I have found it so, as I have never lost a case of mitral insufficiency during or immediately after labor, whereas I have had one death from mitral stenosis. In talking this matter over with several other obstetricians, several of them have lost cases of mitral stenosis, whereas their mortality has been nil with insufficiency. Probably the greatest complication of parturition for the mother and child is acute edema of the lungs. The resulting asphyxiation of the mother invariably leads to the intrauterine death of the foetus. The two greatest dangers arising from the complication of a heart lesion with pregnancy are break in compensation already referred to and degenerative changes in the myocardium, with subsequent cardiac failure. One must not overlook the fact that the patient is not out of danger after delivery, for symptoms of severe heart failure may supervene any time within the next three or four weeks. In one of my patients with a mitral insufficiency who had a comparatively easy and spontaneous delivery and showed no signs of cardiac embarrassment three weeks after delivery she had a bad break in compensation, and died 24 hours afterwards.

THE EFFECT OF CARDIOPATHIES UPON A CO-EXISTING PREGNANCY.

We find the most pronounced expression in premature expulsion of the uterine contents. Statistics on this point as to the relative frequency of premature spontaneous termination of the pregnancy are very unreliable. However, it may be stated with safety that it occurs in about 25 per cent. of all the patients with a cardiac lesion. Premature termination of the pregnancy does not take place unless there is some break in compensation. Various causes have been ascribed. Congestion of the endometrium, due to circulatory disturbances, apoplexies of the placenta or hemorrhages between the placenta and decidua, interference with placental respiration or the defective oxidation of the maternal blood may cause death in the uterus to the foetus from asphyxiation.

Consideration of the question of premature delivery in patients with cardiac disease is still an open one. It cannot be denied that the greatest dangers to the mother develop during labor. In women whose compensation is good, who can stand a moderate amount of strain without showing signs of fatigue, it may be safe to allow the patient to go on to term; but if a break in compensation occurs at any time during her period of gestation, it may be well to consider the question of producing abortion. This is a grave question, and should not be undertaken unless the family and another physician are called into consultation. With quiet and rest in bed, many of these patients who have had breaks in compensation may go through labor without the least bit of embarrassment, whereas if we had terminated pregnancy, the child would have been lost. We must not lose sight of the fact that the production of premature delivery produces almost as much strain on the patient as at full term, except that it may be shorter. The loss of blood in these patients is more beneficial than harmful, and

should not be considered a factor contraindicating premature miscarriage in cardiopathies. However, when we decide to terminate pregnancy, the method employed should be one that produces the least amount of strain on the patient. In three of my cases the question of terminating labor was carefully considered. One patient in particular had a bad break in compensation about the seventh month. This patient was put to bed, absolute rest, on light, nutritious diet, and the infusion of digitalis in tablespoonful doses given. After a three weeks' rest in bed she showed no further signs of a break in compensation. Notwithstanding her labor was quite long, she showed no cardiac embarrassment. I should say that with patients who showed signs of a break in compensation about the sixth month of pregnancy, and did not regain compensation after three or four weeks' rest in bed, with the use of the customary medicinal and therapeutic measures, and if the same patient after this rest in bed again showed signs of decompensation, the question of terminating pregnancy should certainly be considered. Of course, in desperate cases, where the patient is moribund, with the prospect of saving the child, the prompt induction of labor should be attempted, though this in many instances is rather useless, as by the time the baby is born it is already dead from asphyxiation.

As long as the compensation is good, the patient should merely be carefully watched. No medicines need be given. The old practice of giving tincture of digitalis and strychnine many months before labor is really of no benefit. When nature is taking care of the heart—and this is shown by a good compensation—medicine is not called for. The only time that medicine should be given is in breaks of compensation. At the first sings of a cardiac weakness, the usual remedies, such as digitalis or strophanthus, should be given. Ordinarily I use a preparation of digalen in from 8 to 15-drop doses. If an immediate effect is required, I give this hypodermically. Some physicians have recommended the giving of digitalis or strophanthus at the beginning of labor. I have tried this in several patients, and have not seen that these patients did any better than those who had not been given digitalis. However, there is one preparation that is most useful in these cases at the beginning of labor, especially in primipara, and that is morphia in quarter-grain doses, and at sufficiently frequent intervals to procure the quietude of the patient. Morphia in these cases does not stop the labor pains, but gives the patient rest, and she does not exert herself, lessening the strain upon the heart. I have never found any ill effects from the use of morphia.

At the clinic of Schauta, in patients with mitral stenosis pregnancy is terminated as soon as the slightest signs of broken compensation appear. This probably accounts for their low mortality in this class of patients.

In the management of labor in these patients one must be particularly careful. If the slightest signs of heart failure appear

the patient should be instructed not to bear down. The usual heart stimulants may be given, combined with a quarter of a grain of morphia, and, if the first stage of labor is over, forceps should be applied and the woman delivered as quickly as possible. The question of giving an anesthetic in these patients is an open one. MacKenzie says he has never seen a fatality from the use of chloroform, while Hirschfelder advocates ether. In several of my patients, where it was necessary to deliver with forceps, I have used ether, with little or no bad effects. With one patient compensation began to fail at the end of the second stage of labor. I gave her several quarter-grain doses of morphia, and applied forceps and delivered her practically without pain. If the signs of heart failure make their appearance early in labor, with the cervix partially dilated, the outcome may be serious. Here you may have to anesthetize the patient, forcibly dilate the cervix and deliver with forceps, or resort to version. Version is a particularly dangerous operation when not performed by one thoroughly experienced in this line, as the danger of rupturing the uterus is very great; and, besides, with a cervix that is not completely dilated, a great deal of difficulty may be experienced in delivering the child, thereby throwing an extra strain upon the patient by keeping her unnecessarily long under an anesthetic.

Patients with a pronounced dyspnea feel more comfortable in a high, reclining position during labor. In one of my patients the dyspnea was so great that she practically sat up in a chair during the whole period of her labor; in fact, the child was delivered with the patient seated in a large chair.

The application of heavy sand bags on the patient's abdomen during the first stage of labor and soon after the baby is born—this being done (1) to accelerate the dilation of the cervix by keeping the baby's head well against the cervix, and (2) to prevent the large abdominal vessels from suddenly filling—is a method that I have not used. To prevent the abdominal vessels from filling, probably the best way is to place the patient in bed and raise the foot of the bed to an angle of 45 degrees. If the pulse should become irregular, and especially if there is evidence of a dilatation of the right heart in the third stage of labor, post-partum hemorrhage should be encouraged. Ergot is more or less contraindicated in these cases of cardiopathies complicating pregnancy, for the reason that the slight bleeding after delivery of the child is decidedly beneficial to the patient, and particularly where there is evidence of a right heart dilatation.

Operative procedures should be taken with caution, and never without the consent of the family, and another physician should always be called in consultation. In view of the possible grave danger of asphyxiation attending pulmonary edema, the obstetrician should be ready to hasten delivery by instrumental measures. The giving of salt solution in these cases should be done with caution, and it should be only given in fractional doses; probably the

Murphy's drop method by rectum is the best method to give the salt solution. It should never be given intravenously. Asphyxiation is best treated by immediate venesection. In view of the fact that serious complications are liable to follow later, I always advise against the mother nursing her child, as the artificial feeding of the baby insures to the mother more quiet and rest. Of course, if the mother offsets these advantages by mental anxiety and worry at not being able to feed the baby, it may be necessary in these few cases to allow the child to be breast-fed. In artificially feeding these children many difficulties are encountered, because so many of these children are born in a weak and frail condition, and when artificially fed the mortality is extremely high.

I have had but one patient suffering with exophthalmic goitre complicating pregnancy, and I hope I will never be called on to treat another case. This patient had quite a large thyroid, with the usual symptoms of Graves' disease. Of particular interest was her pulse beat. Prior to labor, the pulse averaged between 140 and 160 per minute. During the first stage of labor the pulse beat was 170. At the end of the third stage her pulse beat was about 190, and then it became so fast that I could not count it, while the rhythm was not disturbed and the sounds were clear. Immediately after the birth of the child she had an attack of syncope, and during this attack I could not count her pulse at all. Signs of acute pulmonary edema rapidly set in, and the rales and rattling could be heard almost in the next room. During all this excitement she began to bleed most profusely, before the placenta was delivered, and it was necessary to deliver the placenta quickly, in order to stop the bleeding. In the meantime, the baby had become asphyxiated and had died, and it looked as if the patient would follow within a short time. This rapid pulse rate continued for three or four hours, and almost every minute the edema seemed to increase. I gave her the usual heart stimulants, but they were without avail. After the heart stimulants failed, I resorted to the use of morphia, and this seemed to act like a charm. It immediately quieted her nervous condition, and, while the heart beat did not lessen, yet she was very much more comfortable, and the heavy pressure which she complained of in her chest was almost immediately relieved. After the patient remained in this condition four or five hours, I gave her another dose of morphia, and she went to sleep for two hours. During her sleep the pulse gradually dropped in the number of beats per minute. By the next morning her pulse beat was about 135, with fairly good volume, and she complained of little or no pain. Her condition gradually improved, and about the third week she sat up for the first time. I strongly advised this patient not to become pregnant again, and to have her thyroid gland removed.

When we consider the great dangers of cardiopathies complicating pregnancy, the question naturally arises—whether women with heart disease should marry. This is by no means a settled ques-

tion. We all know that when heart disease is complicated with any condition that throws an additional strain upon it, it endangers the patient's life. However, matrimony and pregnancy are not identical terms, and we do know that the great majority of women with good compensation go through pregnancy without any noticeable ill-effects. Marriage to many girls means an improvement in their social condition. It may mean a life of comparative ease as compared with the possible necessity of earning a livelihood by work. These are factors worth considering when the physician is asked the question whether a girl with a cardiac lesion should be permitted to marry. Indiscriminate denial of marriage to all women having valvular lesions may imply an injustice to many of them. In all cases of valvular lesion, heart failure will occur sooner or later, but it is an open question whether its onset will be precipitated by child-bearing, and it is doubtful if the risk of this is so marked as to justify denying her the right to marry. I should say, however, in women who have a heart lesion, with concomitant pulmonary or renal disease, one should advise against marriage. In view of the high death rate of mitral stenosis, one should be very cautious in advising marriage for these women.

CASE HISTORIES IN MEDICINE. Illustrating the Diagnosis, Prognosis and Treatment of Disease. By Richard C. Cabot, M.D., Assistant Professor of Clinical Medicine, Harvard Medical School. Second edition, revised and enlarged. Boston: W. M. Leonard. 1911. Cloth, \$3 net.

The second edition of Case Histories differs from the first in that the answers to the cases under discussion are given. To my mind this is a distinct advantage, as it gives the teacher a clue as to what the writer believed the condition to be. In the present edition the arrangement of the cases under distinct types is more logical than that used in its predecessor. Here we find cases illustrating the infectious diseases grouped together; the same applies to the maladies of the heart, respiratory tract, urinary organs, etc. Books of this character aptly illustrate the difficulties of the clinician in arriving at a proper diagnosis in border line cases, and afford an excellent medium to test the aptitude of the listener in arriving at an approximate diagnosis. In other words it is calculated to make the hearer use his brains and test his diagnostic ability to arrive at a proper diagnosis. In the present volume the writer has given more attention to prognosis and treatment than in the former, and in order to offset the theory that modern physicians are drug nihilists, has incorporated a chapter on drug therapy and the drugs used in the Massachusetts General Hospital. The present volume will be found every bit as useful as its predecessor, and should prove a great aid to the profession in doubtful cases.

REPORT OF PROGRESS.*

By Prince A. Morrow, M.D.

THIS meeting marks the seventh anniversary of the organization of this society. It is eminently fitting that a report of the progress of this movement should be presented on this occasion, the more especially as we find in this retrospect abundant cause for congratulation in the amount and character of the work accomplished, and, at the same time, the most hopeful auguries for its future success.

On February 8, 1905, a handful of half-hearted men met in this hall in response to a call for a meeting to discuss the wisdom and expediency of forming an organization for the specific object of "The study and prevention of the spread of diseases which have their origin in the social evil." Only about 25 persons responded to this call, and the array of empty benches was so dispiriting that the meeting was adjourned to an adjacent smaller room. The movement so inauspiciously launched, started slowly, hesitatingly, then advanced with more certainty and courage, later boldly and more aggressively, until now it has gained recognition and respect, and achieved no small measure of success. It may be said of this society as of the patriarch of old: "With my staff alone, I crossed over this Jordan, and now I am become two bands." Rather we might say 20 bands, for, as a direct outgrowth of this movement, there have been established 20 organizations with similar aims and purposes throughout the country, with two branches of this society in Syracuse and Buffalo.

In addition, societies are being projected or are in process of formation in several cities.† The growth of this movement has extended beyond the seas. The New Zealand Society of Sanitary and Moral Prophylaxis was organized through the efforts of this society in 1910.

The work of this, the parent society, has been chiefly along educational lines—through public meetings and conferences, the circulation of educational literature and through lectures. Two of its regular meetings have been held in connection with the New York Association of Biology Teachers, and one joint meeting with the New York County Medical Society.

During the last winter the efforts of this society were directed to two specific objects—first, the repeal of the obnoxious Clause 79 of the Page bill, and second, securing Health Department control of venereal diseases in this city, both of which were successful.

There has been a steady growth in the membership of the society. In the year 1911, 295 new members were added to the

*Read at the meeting of the American Society of Sanitary and Moral Prophylaxis, February 8, 1912.

†Since this report was read societies in Massachusetts, Mexico and Southern California have been added to the list.

list. Not only America, but Europe, Asia and Africa are represented in our list of members. An active interest has been created in Japan, and two of the society's educational pamphlets have been translated into Japanese. The work is being done largely through the efforts of the Y. M. C. A. in Japan.

The demand for our literature is large and steadily increasing: 45,000 copies of Pamphlet No. 6, "Health and the Hygiene of Sex," have been printed, and another 5000 is now in the hands of the printer, making 50,000 altogether. Over 25,000 copies have gone to the freshman classes of various colleges and universities, and we have received from the presidents of many of these colleges the most enthusiastic commendations of its value, and assurances of the good it has done. Twenty-eight thousand copies of No. 1, "The Young Man's Problem"; 10,000 copies each of Nos. 2 and 3, 27,000 copies of No. 4, "The Boy Problem," and 15,000 copies of No. 5 have been printed, and, for the most part, circulated.

There has been a large demand for the four-page circular setting forth the objects and aims of the society and the facts which furnish motives to this movement. Nearly 200,000 of these have been printed, and a recent order for 50,000 came from the State of California. In addition, 20,000 copies of the leaflet on the "Need of Instruction in Sex Hygiene" have been printed.

One indication of interest in this movement is the demand from hundreds of libraries for the Transactions of the Society. This is due not alone, it is believed, to the intrinsic value of the papers and discussions, but because they furnish the record of a movement which has excited general interest throughout the entire country.

The *Journal of Social Diseases*, which was intended to serve as the official organ of all the societies, is now established on a permanent basis. The earlier numbers are out of print, and the demand for the Sex Hygiene Number (October, 1911) was so large that two additional printings have been required.

There has been a great demand for lectures. The society has now 10 regularly appointed lecturers. One of the most valuable fields of this lecture work has been found in the meetings of the mothers of the pupils of the public schools. The Public Education Association, under whose auspices these lectures have been conducted, has recently notified the principals of all the public schools in the city that the lecturers of our society are now available for this purpose. Our lecture work is unfortunately restricted by the limitations of the lecture funds.

THE PENNSYLVANIA SOCIETY FOR THE PREVENTION OF SOCIAL DISEASE.

Many large meetings of men, women and boys, segregated or mixed, have been addressed in various cities throughout the State by the secretary on the subject, "The Relation of the Citizen to the Control of Social Diseases." A branch organization has been established in Williamsport. A large meeting was held under the

auspices of the Pennsylvania State Medical Society at Harrisburg, and the movement thus formally endorsed by the State Medical Society.

A Woman's Advisory Board has been added to the effective forces in the field. An effort is being made to enforce the laws already upon the statute books relating to the quarantining by the Health Board of persons afflicted with any contagious disease dangerous to the community, the enforced hospital treatment of any person afflicted with contagious disease who cannot be properly treated at home, and the reporting by physicians to the Board of Health of persons laboring under a contagious, pestilential disease, and the enforcement of laws relating to disorderly houses. It has been found that only one hospital in the State opens its doors to patients suffering from social diseases.

Several editions of 25,000 copies of a circular of information for women have been printed and distributed. A complete set of negatives for the preparation of lantern slides has also been made, illustrating the many extra-genital symptoms caused by social diseases.

A public conference on sex hygiene was directed by this society under the auspices of the Philadelphia Child Welfare Planning Conference November, 1911. A permanent exhibit illustrating the need of instruction and methods to be employed will be used in the work throughout the State. An entering wedge has been inserted, at least in Philadelphia, with a view to the introduction into public schools of intelligent graded teaching in normal sex hygiene.

An effort is being made to secure an endowment fund of \$50,000, as far as possible in endowment subscriptions of \$1000 each, to carry on the work of the society.

CHICAGO SOCIETY FOR SOCIAL HYGIENE.

The literature of this society consists of a 64-page pamphlet entitled "The General Need of Education in Matters of Sex," a pamphlet entitled "The Sexual Necessity," and four leaflets: "Sex Hygiene for Young Men," "Family Protection," "Community Protection," "Prospects and Retrospects."

Requests for this literature have been received from 150 colleges, 400 Y. M. C. A.'s, besides a number of churches, schools, settlements, women's clubs, army and navy people, business people, and others.

Work has been taken up along similar lines by several groups of people here in the city, who are co-operating with our organization.

The first was the Chicago Women's Club, which has taken up the subject especially from the standpoint of the protection of mothers and children and the proper training for children.

Second: A union meeting of ministers, organized as the Illinois Vigilance Association, with a view to working along moral legisla-

tion and law-enforcement lines, for the suppression of the white slave traffic and the reduction of open or notorious vice.

Later the Chicago Vice Commission appeared as an outgrowth of the difference of opinion between the Illinois Vigilance Association speakers and people interested in the subject from the standpoint of municipal government responsibility in the matter.

The result of the Women's Club work has been to introduce the subject into the National Federation of Women's Clubs, the State Federation of Women's Clubs, of a Woman Physician addressing women's clubs, church associations, and other groups of women on numerous occasions for the past four years.

The result of the Illinois Vigilance Association work has been a wide publicity, a good deal of prosecution and law-enforcement, and some State and national legislation for the suppression of white slave traffic and similar crimes.

The result of the appointment of the Chicago Vice Commission has been the publication of the *Vice Commission Report*.

Chicago public schools have, within the past year and a half, made an effort to teach the high school pupils something of the subject of social hygiene.

THE MARYLAND SOCIETY FOR SOCIAL HYGIENE.

The secretary reports that the society has held two public meetings; attendance, 1600. Meetings for boys and men, 41; audience, 1050. Meetings for women and girls, 25; audience, 1550. Total: 68 meetings; attendance, 5200.

Six thousand copies of literature have been distributed. This, however, does not indicate all the work of the society, as the character of the work has been such as to influence a great many people and to produce much thought and discussion upon the subject from physicians, clergymen, teachers, social workers and others interested in the public welfare.

ST. LOUIS SOCIETY OF SOCIAL HYGIENE.

An address given before the St. Louis Medical Society by invitation was adopted by the committee as an official utterance, and 25,000 copies have been sent to carefully selected lists of names, such as the membership of the Civic League, the women's clubs, the ministers and teachers, the City Club, to the 6850 names given in the Blue Book's list of members of clubs in the city, to 8000 of the members of the Citizens' Industrial Association; and 1000 were distributed at a meeting of the Central Trades and Labor Union.

The press of the city has supported our campaign through editorial endorsement, and one paper printed an open letter to the fathers and mothers of St. Louis, urging them to give their children the instruction in matters of sex they ought to have. We have also published and distributed thousands of four-page circulars, as follows:

"The Delinquent Girl," containing typical cases from the report

of a Juvenile Court probation officer, with recommendations for improving the situation.

"A Plain Talk with Boys on Sex Hygiene."

"A Straight Talk with Employers and Leaders of Organized Labor."

"Effect of Venereal Diseases on Young Men."

The medical members of the executive committee and the president of the society are authorized lecturers, and have responded to such requests as have been made for addresses on the part of the parents' societies, clubs, schools, etc.

Our only legislative efforts have been to encourage the city government to pass a bill authorizing a commission to examine the dance halls and report with recommendations for legislation intended to free these places from evil influences now prevalent.

SPOKANE SOCIETY OF SOCIAL AND MORAL HYGIENE.

A series of seven circulars has been published:

1. "The Need for Education in Sexual Hygiene."
2. "A Frank Talk with Boys and Girls About Their Birth." For children 6 to 10 years of age.
3. "A Straight Talk with Boys About Their Birth and Early Boyhood." For boys 10 to 13 years of age.
4. "A Plain Talk with Boys About Their Physical Development." For boys approaching and during puberty.
5. "Sexual Hygiene for Young Men."
6. "A Plain Talk with Girls About Their Health and Physical Development."
7. "Sexual Hygiene for Young Women."

Thirty-three thousand copies of these circulars were issued the first year. During the next year many phases of work were exploited. The committee on local conditions investigated public dance halls in the city. Their report was brought to the attention of many parents at subsequent public meetings as a warning of the dangers of these places.

As a result, the executive committee inspected the penny arcades frequented by boys and men, and, finding many of the pictures grossly objectionable, reported conditions to the Mayor, who ordered the proprietors of the arcades to submit all pictures to the committee for inspection. This was done, and eventually resulted in the appointment of a Board of Censorship over these exhibitions.

Public meetings have been held from time to time as one of the chief means of education.

Through the co-operation of the Board of Education, the superintendent of schools and the principals of the schools, the most successful work of the year was made possible in the present meetings conducted by the society in various school buildings. Eleven buildings were utilized for this purpose, with a total attendance of about 825, an average of 75 at each meeting. The high school principal invited the society to present its work to the faculty, and

as a result a meeting of 250 persons, parents of the students, was held.

Another important work has been the distribution of literature. Eighty-three thousand copies of the circulars mentioned were printed for the first two years, and had wide circulation. Designed for use in Spokane and vicinity, they have gradually come to be known throughout this and foreign lands as the result of notices given them by various magazines and publications. In one year, 900 letters asking for them were received, these representing universities, colleges, high schools, normal schools, women's clubs, Y. M. C. A.'s, Y. W. C. A.'s, church and Sunday-school organizations, publishing houses, moral and social reform societies, army posts, W. C. T. U.'s, rescue homes and many individuals in private life.

There have been numerous requests for our literature from other parts of the country, including Canada, England, Spain, Alaska and India. Some have purchased them in quantity, and, altogether, about 3500 copies have been sent out. The public libraries of Washington, D. C., and Los Angeles, Cal., have requested our circulars to be placed in those libraries.

The third annual report shows that the work consisted during that year largely of an educational campaign. The parents' meetings were continued and numerous other meetings held. Addresses were made at several of the lodges, before the Chamber of Commerce (one of the most enthusiastic meetings of the year), before the Spokane County Nurses' Association and the Y. M. C. A., the W. C. T. U. and mothers' meetings, while the Liberty Park Improvement Club invited the society's speakers to one of its sessions.

Effort was made to secure the interest of the churches in this work, with good success. A beginning was made in giving instruction to the young, addresses having been given to the boys of the high school, to the entire student body of Spokane College, etc.

A new feature was the out-of-town work, particularly a lecture at the Parent-Teacher Conference at the State Normal School at Cheney, since which time the society has co-operated with the Normal faculty in the work dealing with social hygiene. The society also conducted meetings in other surrounding towns, with a total attendance of about 3600 people.

The most tangible result of the society's effort is that in reference to the normal schools of Washington. Largely through the influence of the society, the State Board of Education has incorporated in the curriculum of the normal schools, beginning with the fall term of 1911, a course in sexual physiology and hygiene. This course consists of 18 classroom periods, and is required of all students who expect to graduate.

In complying with the State law, the following recommendations of the principals of the normal schools have been adopted:

First—That the State require each student who takes the 'sec-

ondary or a diploma in the State Normal School to earn one credit in sex and moral hygiene.

Second—The school gives a series of talks to the summer school students who are entered in the physical training classes. In the fall of 1911 all students asking for secondary or advanced diplomas were given two periods a week for one semester. The students are expected to take notes and take part in the discussion. They expect to get out a bulletin every month for distribution, and the teachers over the State write this school almost daily, asking for information. They have never given instruction to mixed classes, women physicians instructing girls, and men instructing men. Talks have also been given to boys by Dr. J. G. Harbison of the Spokane Society of Social and Moral Hygiene. Although the boys have no regular courses, they probably will have next year. The subject is treated in a general way, first from the biological standpoint; second, the pedagogical; third, the sociological. The pathological aspects are treated relatively to the above three divisions—frankly, but without undue emphasis.

During the year the society went on record as unalterably in favor of suppression and eradication of prostitution and opposed to the establishment or maintenance of a restricted district.

Efforts are being made toward presenting the work to the labor unions for consideration; also toward extending it to other cities.

SOCIAL HYGIENE OF PORTLAND, ORE.

The publication committee has issued two leaflets, one setting forth the need, importance and method of the work; the other, No. 2, being entitled, "The Four Sex Lies."

The committee has scheduled a series of 44 parents' meetings to begin November 9, invitations to these meetings being printed and enclosed in envelopes and given by the teachers to the children to take home to their parents. About 60 were present at the first meeting and 100 at the second. Others will be held later.

The committee on social hygiene are preparing a group of lantern slides to be used by the lecturers. A committee on Y. M. C. A. and education has outlined a plan involving the education of the entire Y. M. C. A., both boys and men, and will use both lectures and printed matter in their work. They have held one fathers' meeting, at which 65 men attended.

The committee on public education has planned to give lectures and to distribute printed matter through the co-operation of women's clubs, the public library, insurance companies and through the co-operation of employers in department stores, factories, railway and street car companies. The assistance of a business men's committee has been secured in order to have the co-operation of employers.

A lecture has been given before an organization known as the "Big Stores," which has an audience of about 100. Groups of students in business college, Y. M. C. A., military academy, etc., have been addressed. Also meetings of business men have been

held. The committee has also undertaken to review a large number of books, with a view of selecting and classifying the best.

COLORADO SOCIETY FOR SOCIAL HEALTH.

The secretary reports that this society has used the literature of the other societies for distribution. Considerable work has been done in securing the enactment by the Colorado Legislature of drastic law in dealing with the macquereaux throughout the State. Arrangements have also been made for having sexual hygiene taught in the schools. A questionnaire letter addressed to each minister in the State is now being issued, asking for their co-operation in instructing the people in a careful and definite way as to the prevention of social diseases.

CALIFORNIA SOCIETY FOR THE STUDY AND PREVENTION OF SYPHILIS
AND GONORRHEA.

The secretary reports that, while the society has not been able to continue work as aggressively as they had wished, partly because they lack the funds and partly for other reasons, they have accomplished some good work.

Some of the members of the society have been called upon to address various clubs and societies, and public meetings have been held. Steps have been taken, indirectly through the influence of the society, toward the education of young people attending the public schools. The State Board of Health has co-operated with the members of the society, and has established a bulletin which has added greatly to the interest of the society's work.

DETROIT SOCIETY OF SOCIAL HYGIENE.

The work of this society has been a campaign designed to awaken the people to the needs of scientific education on sex hygiene.

Addresses before public meetings were followed by lectures to small groups of men, boys, women, factory women and girls by a local lecture corps of 20 men and women physicians. More than 100 of these talks have been given. Pamphlets have been issued on the following subjects:

1. "A Word to Parents on Sex Hygiene."
2. "To the Girl Who Does Not Know."
3. "A Plain Talk with Boys."
4. "Some Plain Facts for Young Men Upon Sexual Matters."

About 30,000 leaflets have been printed, the most of them distributed, partly gratis and partly paid for.

Meetings have been held in conjunction with the Wayne County Medical Society. At one of these meetings the subject was "Shall Venereal Diseases Be Reported to the Board of Health?" The consensus of opinion was that the diseases were dangerous and communicable, and should be under Board of Health control. Other organizations of men and women in Detroit were asked to include in their programs for the year some discussion of the sub-

ject of sex hygiene, with a view to improving conditions along social, moral, hygienic, legislative, and law-enforcement lines.

INDIANA SOCIETY OF SOCIAL HYGIENE.

The Indiana State Board of Health has three or four lecturers in addition to the Commissioner of Health, Dr. J. N. Hurty. These lecturers, combined, give from 5 to 20 lectures a week during the fall, winter and spring, and some lectures during the summer. They have also issued a pamphlet, 100,000 copies of which have been printed. They work in connection with the Y. M. C. A., with churches, with women's clubs, civic and business organizations, or any group of people desiring information. The lecturers are in the pay of the State Board of Health, and the traveling expenses are paid by the State.

MILWAUKEE SOCIETY OF SOCIAL AND MORAL HYGIENE.

This society was organized several years ago, and has been working locally. Some of the members are interested in rescue and reform work for girls, and have devoted more of their time to that than to the society proper. A substantial membership, and is working effectively.

THE WEST VIRGINIA SOCIETY OF SOCIAL HYGIENE.

The secretary reports that the society has held six public meetings, the audience varying from 50 to 300 people at each meeting. Several hundred copies of the society's literature and the literature of other societies have been distributed. The bulletin of their organization shows the membership of medical and non-medical people, including the Governor of the State. In addition to the society's work, Dr. S. L. Jepson, editor of the *West Virginia Medical Journal*, has given a number of lectures upon the subject of sanitary and moral prophylaxis. These lectures have been delivered in nine of the principal cities of the State, and the total attendance has amounted to 2350.

(To be Continued.)

THE TAYLOR POCKET CASE RECORD. By J. J. Taylor, M.D., Philadelphia: The Medical Council Company. 1911. Red limp leather, \$1.00.

In recent times physicians have gotten out of the habit of keeping records. The object of this book is to encourage doctors to study their cases more thoroughly and to keep more accurate records. As its bulk is such as to occupy very little space in the hand satchel, it should be a potent agent in this line. It is so arranged that the necessary data can be registered in the minimum amount of time, and should certainly tend to thoroughness if employed in our daily work. There are complete directions for its use, and the book provides for 120 cases.

LA GRIPPE: ODONTO—NEUROSIS.*

By *Wm. A. Mills, D.D.S., Baltimore, Md.,*

Lecturer on Nitrous Oxide Anesthesia, Baltimore Medical College, Dental Department.

Ever since the bacillus of Pfeiffer was introduced into the United States in the early seventies, every winter season, with its varying and sudden changes of climatic and atmospheric conditions, it appears annually in some new form of constitutional disturbance, and numbers its victims by the thousands.

This micro-organism, it is claimed, enters directly into the blood-current; in severe attacks the whole nervous system loses its equilibrium, due more to a rapid increase in leucocytes, causing anemia, than to a diminished production of the red blood-corpuscles; thereby reducing their power to overcome the toxin or toxins thrown off by the germ or others in combination with it.

This zymotic hydra is of such a metastatic order when one treats a patient he may have to combat not only one evil, but many complex conditions.

It may assume the form of a simple inflammation, influenza or may develop something of a more serious character; and if the subject recovers often some organic lesion remains as an aftermath.

Some years ago an original paper was read and discussed before this Association, entitled *La Grippe: Odonto-Metastasis*,† and at a later meeting another on *La Grippe: Odonto-Multifistulous Abscess of the Alveolar Process*.‡

Again your attention is called to another expression of the same dyscrasia; while not quite so serious in its effects as were those of the former, yet it can be said are closely related; and as it partakes of a dental feature it should be of much interest to the stomatologist, as he is likely to be the first consulted.

During the late unprecedented winter many people have sought relief from excruciating darting pains, centered apparently at the molar process, radiating upward to the frontal sinuses, then to the ear, and temporal fascia, thence down the nasal passage to the alveolar structures and associated parts of the superior maxilla; from the canine fossa to the tuberosities.

The paroxysms at times being so intense as to prevent sleep; this state has existed for three or four days before seeking advice. Odonto-rheumatoid arthritis was suspected, but the surmise proved to be in error.

Everyone had a light gripal coryza, with low fever and sub-normal pulse. From a single nostril flowed periodically a thick secretion, the color and consistency of the yolk of an egg. Only slight edema of the cheek was noticed lying just beneath the osmala on the affected side, yet the sufferer said it felt as big as a goose-egg.

*Read before the Baltimore County Medical Association, March 20, 1912.

†Published in *Dental Cosmos*, March, 1904.

‡Published in *Dental Cosmos*, September, 1904.

The most remarkable feature was: All symptoms and conditions were alike and confined only to one side of the head, being strictly semi-cephalic.

On examination of the oral cavity the teeth, mucous membranes and bony tissues were all found to be normal, except in one instance, where a pulpless second molar was involved; but when strong digital pressure was brought to bear upon the buccal surface of the antrum of Highmore *they cried out in distress*.

Then the ailment was diagnosed as a gripal infections of that cavity and other air chambers, as was evidenced by the catarrhal discharge, causing a neurosis of the nerve centers and filaments of the implicated mucosa; hence the extensive neuralgic field.

Treatment was both local and systemic, but simple, with quick recovery, and as far as known no bad after-effects have followed.

For an analgesic was given:

R Menthol crystal, grs. xxx.

Sig. Heat small portion and inhale vapor.

To correct faulty metabolism was prescribed:

R Aspirin, 5i.

Capsules No. 12.

Sig. Two capsules after each meal first day, one after each meal thereafter.

Of course, the cleansing of the alimentary canal with saline laxatives is the first thing to be recommended.

In making inquiry of a few general practitioners if they had any cases like those described, one said he had it himself, and others had met several, while others had to fight only cervical abscesses; and it was remarked at the time that the latter affliction was endemic in Roland Park.

It is presumed not to be foreign to the subject under discussion to speak of the investigations made during the past week by several Baltimore physicians to find the cause of the present epidemic of malignant sore throat.

In the press of yesterday it was stated that a new microbe had been isolated from milk and that the source of infection had been traced to a cow with an abscess.

It is suggested that this newly-found thing, when more fully examined and studied, may prove to be a very close relation to the common enemy—old la grippe.

In conclusion, nothing more descriptive or appropriate can be said or written of the traits of this Russian fiend than the following by Dr. Howard S. Andere: "La grippe in its symptomatic manifestations is the hysteria of epidemic disease. Its puzzling obscurities, unique development, grotesque variations, distressing complications and surprising sequelae make it paradoxically typical of the atypic in the class of infectious diseases. No tissue seems too strong, no tissue too hidden, no function too stable, no organ too resistant, no organism too robust to escape its Briavian grip."

Book Reviews.

SPONDYLOTHERAPY. Physio-Therapy of the Spine Based on a Study of Clinical Physiology. By Albert Abrams, A.M., M.D. (University of Heidelberg), F.R.M.S., Consulting Physician to the Mt. Zion and French Hospitals, San Francisco; formerly Professor of Pathology and Director of the Medical Clinic, Cooper Medical College (Department of Medicine, Leland Stanford Junior University), San Francisco. Third edition, enlarged. Philopolis Press, San Francisco, Cal. Cloth. 1912.

Undoubtedly in our wild chase after this remedy or that remedy spinal therapy has been but slightly considered. This may have come about from the fact that this method of treatment has been the particular field of the osteopaths. Be this as it may, there is no doubt that spinal therapy has not received the attention it should from the regular practitioner, and if one carefully digests the pages of Professor Abrams he is brought to a keen realization that much can be done for certain classes of patients by this line of treatment. Of course, one must not lose sight of the fact that Dr. Abram's enthusiasm may have led him to overdraw the results obtainable by this line of therapy, but such is the case with the general run of specialists when describing a new method of treatment. The time has come when the medical mind must receive openly the claims of others as to new lines of therapeutic effort, and before casting them aside to test their efficiency. Heretofore the medical fraternity has begrudgingly tried out innovations, and in most instances, as a matter of fact, have condemned them without a trial. In order to bring to the attention of the profession what might and what might not be expected of electric, hydriatic and mechanical applications to the spine the author has produced the above-named book of some 600 pages. He therein sets forth concisely and plainly his experience and gives physiologic reasons for the same.

SURGICAL CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Volume 1. Number 1. Octavo of 133 pages, illustrated. Philadelphia and London: W. B. Saunders Company. 1912. Paper, \$8 net. Cloth, \$12 net. Baltimore: The Medical Standard Book Co., 307 N. Charles Street. Published Bi-monthly.

Anything from the pen of Doctor John B. Murphy is well worth while, as for many years he has stood at the head of the surgical profession of the United States. His present contributions to medical literature, however, should awaken more than usual interest, as they are somewhat of a departure from the customary manner of presenting surgical subjects. It is the intention of the publishers to issue the Clinics bi-monthly, namely six times a year. For some time there has been a demand by the pro-

fession for literature more clinical in character, and to meet this call Doctor Murphy has consented to publish his Wednesday and Saturday clinics in book form for the benefit of those who are unable to attend, and thus to give a wider publicity to his methods. The history of each case is given, then follows the comments of Doctor Murphy covering the technic of the operation, the diagnosis, the methods of arriving at the same, and all the points involved in the living pathology of the particular type of case. These publications are verbatim stenographic reports of Doctor Murphy's clinical talks, but are of necessity edited to eliminate repetition, which repetitions are not eliminated, however, when necessary to emphasize the question in hand. The present volume is well illustrated with photographs, sketches, and skiagraphms, and we are further assured that future volumes will be likewise elucidated. Among the subjects treated in the February number are: carcinoma of the breast, lipoma of the shoulder, varicocele, nerve anastomosis, sarcoma, cystadenoma of the breast, fracture of the patella, Charcot's disease of the hip joint, epithelioma of the nose, duodenal ulcer, hemangioma of the leg, fistula in ano, etc.

When reading the several subjects discussed one can imagine that he is really in the presence of the distinguished surgeon himself, and when the price of the series is considered eight or twelve dollars for the six issues, according to the binding, one fully realizes the debt of gratitude the profession is under to the author and publishers for consenting to place such valuable material on permanent record.

PRACTICAL GYNECOLOGY. A Comprehensive Textbook for Students and Physicians. By E. E. Montgomery, M.D., LL.D., Professor of Gynecology, Jefferson Medical College; Gynecologist to the Jefferson Medical College and St. Joseph's Hospital; Consulting Gynecologist to the Philadelphia Lying-In Charity, The Kensington Hospital for Women, and Consulting Surgeon to the Jewish Hospital. Fourth edition, revised and rearranged. With 589 illustrations, the greatest number of which have been drawn and engraved specially for this work, for the most part from original sources. Philadelphia: P. Blakiston's Son and Company. 1912. Cloth, \$6 net.

Montgomery has again succeeded in giving us one of the best single volume textbooks in gynecology on the market. From his experience as a teacher he has to a nicety gauged the material necessary for a proper understanding of the subject by a student, telling what he has to say in a positive manner, and leaving out of consideration mooted points and unnecessary luggage. He has thereby succeeded in producing a book sufficiently comprehensive to cover the gynecological field without rendering the book too cumbersome for student and general practitioner purposes.

The cuts are very well selected and materially assist in elucidating the text. The opening words are devoted to the embryology of the generative organs and special anatomy. There is no doubt that too little attention as a rule is paid by the surgeon to the embryological consideration of the subject under discussion, and we are more than pleased to see that Montgomery has not neglected this important feature, for nobody can properly understand the diseases of a system without having a knowledge of its embryological formation. Diagnostic technic is sufficiently treated to give a thorough understanding of the basic principles of that important subject. Therefore, taken all in all, the present edition of Montgomery's Gynecology will be found sufficiently comprehensive and embrative to suit the taste of the most critical reader.

A SURGICAL TREATMENT OF LOCOMOTOR ATAXIA. By L. N. Denslow, M.D., Fellow New York Academy of Medicine; Late Physician, Diseases of the Skin (Out-Patients), Bellevue Hospital, New York; Late Professor Genito-Urinary and Venereal Diseases, St. Paul Medical College, Minnesota. London: Bailliere, Tindall & Cox, 8 Henrietta street Covent Garden. 1912. Cloth, 3 shillings and 6 pence.

Denslow has obtained such good results by the use of surgical measures in the treatment of locomotor ataxia and his methods have attracted such widespread interest that he has consented to give his technic in book form so that those desiring information in the same can get it at first hand. He states that in male subjects in every case without exception an abnormal condition of the urethra exists, and that by treatment directed to this condition many of the symptoms of the disease, the pains, the ataxia, visceral crises, hyperesthesias, anesthasias and incontinence of urine and feces may be cured or alleviated, and the disease itself at least held in check. He goes on further to say, it need scarcely be said that permanent pathological changes are irreparable, and in that sense a cure is out of the question; but where a train of symptoms is due to some irritation, and this is stopped by removal of the cause, undoubted good may be achieved. He willingly admits that in his belief all cases of locomotor ataxia are ultimately due to lues. But granting this as essential, he states other conditions have to be reckoned with. In other words, syphilis alone may not suffice to produce the disease; other factors may be needed to call it forth, and among these urethral irritation in the male occupies the most prominent place. Believing this to be the case, Dr. Denslow seeks out, therefore, the urethral cause, upon which he institutes the proper treatment, with, as he claims, considerable results in his hands. The doctor cites a number of cases to substantiate his treatment, and also includes a chapter in explanation as to why urethral irritation acts as a causative factor in the production of tabes. If further investigation bears out Dr. Denslow's statements, a marked advance has been made in the

treatment of this unfortunate group of patients. At any rate, the book is well worth a careful perusal.

A COMPEND OF GENITO-URINARY DISEASES AND SYPHILIS. Including their Surgery and Treatment. By Charles S. Hirsch, M.D., Formerly Assistant in the Genito-Urinary Surgical Department, Jefferson Medical College Hospital; Consulting Physician, Social Service Hospital and Juvenile Protective Association, Philadelphia. Second Edition. With 74 Illustrations. Philadelphia: P. Blakiston's Son and Company, 1012 Walnut street. 1912. Cloth, \$1.25 net.

To the reviewer's mind this book should be designated as a manual rather than compend. It contains a great deal more information than one would suppose possible, and will be found by the student of great aid in reviewing his year's work. It is true that the rarer affections are left out, but this is made up for by the thoroughness with which those included are treated. A description of the surgical anatomy of the organs of the urogenital tract precedes the technique of the various operations, and the newer aids to diagnosis are not forgotten, cystoscopy, ureteral catheterization, cryoscopy, X-ray, etc. The treatment will in the main be found to coincide with the accepted principles of the day. The book is cheap at its price.

PRINCIPLES AND PRACTICE OF PHYSICAL DIAGNOSIS. By John C. DaCosta, Jr., M.D., Assistant Professor of Clinical Medicine, Jefferson Medical College; Assistant Visiting Physician, Jefferson Hospital; Hematologist, German Hospital; Fellow of the College of Physicians of Philadelphia; Associate Member of the Association of American Physicians, etc., etc. Second edition. Thoroughly revised. 225 original illustrations. Octavo of 557 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1911. Cloth, \$3.50 net.

For the price no such book can be obtained on physical diagnosis and its principles. This branch of medicine has today grown by such leaps and bounds that it is indeed difficult to include them in a single volume book, let alone keep the book within reasonable limits as regards number of pages. Doctor DaCosta has, however, succeeded in accomplishing this feat, and withal has made a thoroughly reliable book. Not only have the ordinary methods of physical diagnosis been touched, but also many of the newer methods, chiefly in connection with the subject of sphygmomanometry, nodal ryth and lobar atelectasis. Besides many new illustrations have been included which materially help in clarifying the text. Students, as heretofore, and even practitioners of medicine will find this book to excellently meet their needs in questions of physical diagnosis.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, APRIL, 1912

TECHNIQUE AND REMOTE RESULTS OF VASCULAR ANASTOMOSIS.

ALTHOUGH the possibility of uniting severed blood vessels was known and practically demonstrated as early as the seventeenth century, it has only within the past decade come into popularity. The method employed by Carrel was evolved nine years ago and was based on the technique employed by Payr and Murphy, and its principle was first worked out on human cadavers and two living dogs at the University of Lyons (Carrel, "Surgery, Gynecology and Obstetrics"). It then became possible to perform successfully blood-vessel anastomosis. Later, from experiments made at the University of Chicago and the Rockefeller Institute for Medical Research, the possible causes of failure were worked out and adequate measures developed to prevent their occurrence. With this knowledge in hand, and the technique slightly modified from time to time as occasion demanded, and as experiments on animals proved its efficiency, the method was transferred from the laboratory to actual practice on the human being, with, as is well known, gratifying results. The technique as at present evolved, according to Carrel, is:

1. A rigid asepsis is absolutely necessary. Sutures of blood vessels must never be performed in infected wounds. Thrombosis must be avoided by not injuring the walls of the blood vessels with forceps or other instruments. If forceps, therefore, are employed for control of the circulation, they must be smooth-

jawed and the pressure of the jaws carefully regulated. Desiccation of the endothelium may also lead to the formation of a thrombus; consequently during the operation the internal lining of the vessels must be kept moist by the use of sterile vaseline. As coagulated blood or foreign tissue on the interior can determine the production of thrombus, it is necessary to remove the external sheath from the edges of the vessel, for if during suture it gets between the edges of the vessel it may lead to an obliterative endarteritis. As the endothelium is punctured by the needle, these wounds should be rendered as harmless as possible by the use of very fine needles. The threads should also be heavily coated with sterile vaseline.

2. Hemostasis is secured by Crile clamps or by elastic-jawed forceps. The needles are round, straight needles, Kirby No. 16, and are handled by the hand, not needle-holders.

3. The vessels are exposed by a large incision, and are freely dissected. Careful hemostasis of the wound is made, because during the suture the operative field must be free of blood. Temporary hemostasis are secured by clamps, etc.

4. The anastomosis consists of uniting the rents of the vessel by continuous suture. Great care is taken to approximate accurately the surfaces of the section of the wall. The raw surface must not come in contact with the blood stream.

5. Before the circulation is re-established the line of suture is carefully examined, and if a gap is found it is immediately closed. Then gauze sponges are placed on the line of suture, the clamps removed, while gentle pressure is made on the sponges. There is almost always some leakage during the first minutes. After two or three minutes the sponges are removed, and if some hemorrhage persists, one or two complementary sutures are added and the wound closed without drainage.

Many anastomoses, both on animals and the human being, have been performed by this method with very gratifying results. Carrel could observe no stenosis, and maintains the results remain excellent for a long time.

THE RELATION OF PELVIC DISEASE IN WOMEN
TO RHEUMATOID ARTHRITIS.

TODAY it has been fairly well established that the joint disease spoken of variously as rheumatoid arthritis, arthritis deformans, rheumatic gout, etc., is infectious in character. When a patient suffering with this affection presents himself for advice, it is the duty of the physician to endeavor to locate the point of suppuration. Sometimes it is well-nigh impossible to find the offending area, but if our examination is thorough enough, or if the means at hand were sufficiently delicate, the task would always be possible. Be this as it may, patients afflicted with rheumatic gout have been materially benefited by curing such local inflammations as pyorrhea, alveolaris, enteritis, cholecystitis, inflamed hemorrhoids, etc. Pelvic disturbances in the female have also been found a prolific source of origin of this trouble, and when no other seat of possible inflammation can be found in women the generative organs should be given a thorough examination, and if such disturbances as chronic endometritis, endocervicitis, ovaritis, etc., are detected, the correction of these maladies will result in prompt alleviation of the joint disturbances. Although the scientific study of this group of arthritic maladies is only in its incipency, much knowledge concerning them has been forthcoming, and from what material has already been collected it does not seem a too optimistic prediction when we forecast their prevention in the future. At one time they were supposed to be due to errors in diet, and then to heredity, but the latest theory, as stated above, is that infection is the causative factor in every instance, and some authorities assert that a seat of infection would be found in every instance if our methods of diagnosis were sufficiently developed. Therefore, when called upon to treat joint affections of this nature, it should be the constant endeavor of the physician to discover the focus of inflammation and direct treatment to it rather than the joint itself.

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THE TRIBUTE TO THE MINOTAUR.

By Jefferson R. Kean, M.D.,
Lt.-Col., U. S. A., Washington, D. C.

THE magazine of the National Geographic Society published recently a most interesting account of some excavations in the Island of Crete which have uncovered the city of Knossos, where existed a vigorous civilization before the date of the Trojan War, and the palace of its King Minos, whose name is connected with the earliest traditions of the Athenian people. According to these traditions, King Minos, who was perhaps the earliest exponent of sea-power in history, conquered Attica because his son had been murdered there, and compelled the Athenians to send an annual tribute to Knossos of seven youths and seven maidens, who were thrown into a great dungeon called the labyrinth, where they were devoured by a monster named the Minotaur, a creature (the product of a crime against nature) who had the body of a man, but the head of a bull and the teeth of a lion. The hero Theseus, when he came to Athens to claim the succession to his father's throne, heard at the spring equinox the lamentations of the people when King Minos' herald came in a ship with a black sail to demand the tribute, and he offered himself as one of the victims, in the hope that he might slay either the cruel king or the man-devouring monster. King Minos admired the bold youth, and would have spared him, but he demanded to be thrown as the first victim to the Minotaur. But the King's fair-haired daughter, Ariadne, admired him also, and came by night to bring him a sword with which to slay the monster and a clew of thread by which he might find his way back out of the labyrinth to the upper air. So we see that woman's wit and her gentle sympathy are necessary even to the success of heroes.

Is it too far a cry from ancient Knossos to this great and modern city of Baltimore? May not King Minos represent for us the power of nature, beneficent and yet cruel, and the Minotaur these diseases that are the tribute paid by a society which disregards her laws? The dust of 40 centuries has filled King Minos' dungeons, but still this and every other city pays continually the mel-

ancholy tribute of youths and maidens who with shame and tears are sacrificed to the Minotaur of lust and the terrible diseases by which he mutilates and destroys his victims. To no hero can it be given in these modern days to kill this monster, but much can be done to check his ravages, and we can at least learn from the story that woman is a brave and efficient ally, and we can also by open and free discussion let in the light of truth and knowledge to the dark labyrinth of ignorance and false shame, where the monster makes his home.

The American Public Health Association has a standing committee on the education of the public as to the communicability and prevention of the social diseases, of which committee I am a member. I feel, therefore, that it is in the line of my duty as a member of it to speak to you tonight, and I will later make some quotations from the reports of that committee.

It costs much to our Anglo-Saxon race to lift the taboo which has always heretofore forbidden the discussion of matters which touch upon the sexual relations, and I admire much the civic courage of the men, and especially the women, who are willing to break this taboo and make an effort to stay the plague which has so spread under the protection of our prudery, timidity and narrow-mindedness that the situation threatens the foundations of the social edifice and compels attention.

I wish first to say a few words as to the magnitude of the tribute which modern society pays to the Minotaur, and then touch upon the agencies which we may call to our aid in the fight against him.

Outside of the military services there exists no statistics of the prevalence of these diseases. Dr. Prince A. Morrow, basing his statement, I believe, partly on statistics collected in this city in 1907, says: "Assuming that our population is more virtuous than that of Europe, it must be a conservative estimate that in this country the morbidity from gonorrhea would represent 60 per cent. of the adult male population, and that of syphilis from 10 to 15 per cent., which would mean that between three and four million cases are annually treated in this country. According to this same author, 20 per cent. of the cases occur before the 21st year, 60 per cent. before the 26th, and 10 per cent. of the men who marry infect their wives. It is well known that 25 per cent. of all the total blindness in this country is due to the gonococcus, and that a large proportion of all gynecological operations on women is due to the same cause. It must also be credited with a large part of the sterility in both sexes. In the male it is the cause not only of much permanent injury to the reproductive organs, but of inflammations of the bladder and kidneys, also which cause much invalidism and many deaths. Much of the chronic rheumatism is due to this infection, and we sometimes see men carried off suddenly in the prime of life by its invasion of the heart.

The formidable character of the syphilitic infection is much more a matter of common knowledge. In the words of Osler:

"There is no organ in the body or any tissue in the organs which syphilis does not invade; and it is manifestly difficult to speak at all concisely of the pathology of the disease, just as it is almost impossible to describe its clinical symptoms without mentioning every symptom of every disease known." Besides its more common and familiar manifestations, it should be credited with much of the infant mortality, with most of the paralyses of men under 40, and with probably all of the cases of locomotor ataxia and paresis. It is concealed under almost every conceivable cloak in the death certificates, and is not reported in the living, so we have no accurate statistics of its occurrence in civil communities, although every practicing physician meets it with terrible frequency. We must go, therefore, to the military statistics of the army and navy for exact knowledge on the subject. I grieve to say that our army and navy have a bad eminence above the other nations of the world in the morbidity for social diseases, and our rates have been steadily getting worse of late years, when there is a marked tendency on the part of other nations to improve.

Strangely enough, too, this bad record cannot be considered an evidence of a poor and debauched quality of recruits, for the material that fills the ranks of the army and navy was never so intelligent, self-respecting and typically American as at present. We do not now enlist any but Americans, and the character as well as the physique of the recruits is carefully looked into. Drunkards, vagrants and toughs are not wanted, and are not accepted, and most of our recruits are wholesome, clean young fellows from the country and the small towns. The soldiers and sailors of the nation are today picked men. Only 14 per cent. of the applicants are accepted, and for every man enlisted in the army six are turned away.

The Chart "A"* shows the number of men in each thousand infected in each year with these diseases, or what is known among statisticians as the rate per 1000. You will see that in the last decade it has been continuously more than double what it was for the years preceding the Spanish War. The navy has also shown a similar increase, but later. We are informed by the navy medical reports that this increase is more apparent than real, because on many ships the surgeons did not report these diseases until the recent awakening of the sanitary authorities to the necessity of active measures of prevention. This increase is the more mortifying because it is the only dark page in a record of splendid accomplishment in preventive medicine by the medical officers of the army.

Yellow fever has been conquered; malaria at the army posts in the United States and in Panama and the Philippines has been greatly reduced; tropical dysentery has been brought under control; beri-beri, the greatest cause of non-efficiency and death among our native Filipino troops, has been entirely wiped out, and last, but not least, the army has been rendered immune to that great scourge, typhoid fever. But while the general sick rates

*Chart "A," which we are unable to reproduce, shows that venereal disease in the Army and Navy has increased from an average below 96 per 1000 in the 1880's to one of 160 per 1000 in the 1900's, running its highest in 1902. The big upward jump from 80 per 1000 in 1898 to 136 in 1899 and 152 in 1900 may be due to the fact that the disease was first reported to a greater extent about that time.

continue to improve, this pestilence that walketh in darkness rages unchecked.

The Surgeon-General said in his annual report for 1910:

"The venereal peril has come to outweigh in importance any other sanitary question which now confronts the army, and neither our national optimism nor the Anglo-Saxon disposition to ignore a subject which is offensive to public prudery can longer excuse a frank and honest confrontation of the problem. There is no reason to think that these diseases are beyond the reach of preventive medicine any more than other contagious diseases, and their immunity from restriction must be attributed to the public disinclination to discuss them and legislate concerning them."

The last annual report of the Surgeon-General showed that the number of cases of typhoid fever, malarial fever, smallpox, measles, mumps, scarlet fever, diphtheria, dysentery, tuberculosis and pneumonia, all taken together, were 3737, while the cases of the venereal diseases numbered 11,211—three times as many as for the long list of other infectious diseases which I have just enumerated.

This wholesale poisoning of thousands of these fine young fellows is a sad and shameful spectacle, which our people should not be willing to contemplate with folded hands. The startling contrast shown in Chart "B"* between our army and those of other nations (which are certainly not more moral than we) shows that we must be up and doing, and no longer content ourselves with the cynical and puritanical comment that the wages of sin is death, and that it is not our business to save these young men from the results of their own vices. For the policy of inaction in America, I regret to say, the women are to not a small degree responsible. This attitude is unpatriotic and unchristian. It is the attitude of the Pharisee on the road to Jericho, who passed by on the other side. It has nothing in common with the spirit of that Christ who was the friend of publicans and sinners, who pardoned with a gentle admonition the woman taken in adultery, and who did not disdain the love and worship of the courtesan, Mary Magdalene.

While, therefore, we must support with all our might the efforts of the religious teachers and moralists who are urging a campaign of moral prophylaxis, we must not content ourselves with moral agencies, for we may be sure that though much good may be done, they will be potent only for the minority. Nature in her care for the perpetuation of the race has made the reproductive impulse the strongest and most imperious of human desires and passions and of animal instincts. This passion overcame the morality of the great Psalmist of Israel, and of many another great and good man in ancient and modern days. How can we expect the young soldiers and sailors, honest, but simple-hearted and easily led, full of youth and manly vigor, denied the natural resource of marriage and cut off from the restraining influences of home, to be guided by the principles of morality rather than by the promptings of nature and the seductions of pleasure. The experience of all the

*Chart "B" shows that most nations have a much lower ratio of venereal diseases in their armies than the U. S., the statistics running from about 14 to 1000 in Bavaria to 158 per 1000 in our Army and over 160 per 1000 in our Navy. Bavaria, Prussia, France, Japan, Russia, Austro-Hungary, Great Britain and Spain all show less venereal disease than we do. In the first four countries named the proportion is 24 per 1000 or less.

ages shows that we cannot expect it. Kipling, the soldier's poet, makes his Tommy say:

"We arn't no thin red 'eroes, nor we arn't no brackguards too—
But single men in barricks, most remarkable like you—
An' if sometimes our conduck isn't all your fancy paints,
Why, single men in barricks don't grow into plaster saints."

What, then, shall we do? The sanitarian replies at once: treat these diseases like other infectious diseases, and apply to them the well-known principles of preventive medicine.

It is generally recognized by all who have studied the question that the prostitute is the principal purveyor of venereal diseases, and this is especially true of the spread of them among the young unmarried men who fill the ranks of the armies. It seems logical, therefore, to conclude that the initial and fundamental step in the control of these diseases, both in the military services and in civil life, is the bringing of diseased public women under some form of sanitary supervision and control. But the question is unfortunately far from being one of preventive medicine only, like the prevention of tuberculosis or diphtheria. The moralist, the sociologist and the penologist must be called in council, and their demands, however difficult, conflicting or visionary, given a hearing and met, compromised or answered before the greatest and most essential step in venereal prophylaxis can be taken. So far in our rather crude and unscientific systems of municipal government, no effective attempt has been made to solve the problem, and prostitution has been treated on the antiquated theory of the old English law that it is a nuisance to be handled by the police as a question of public order. The results have been that the police, the minor courts and municipal politics have been corrupted, while the fundamental question of public health has been lost sight of and neglected until the venereal plague, with its wake of ruined lives and wrecked homes, threaten the present happiness and the future development of the race.

The sanitarian claims that the law intervenes not only to prevent the spread of other contagious diseases, but controls certain honest, but dangerous, trades to see that the community suffers no harm, and this trade should not be privileged to destroy because it is vicious and shameful. But at once the clamor begins that the question is one of morals and must be decided on moral grounds: it is immoral to make vice safe; it is an assault upon the sex to examine these women, etc. A new and shriller note has recently been added, which proclaims votes for women as the first step in the regeneration of mankind.

But can we wait for the regeneration of mankind? Can we depend solely on moral agencies which have in 19 centuries left the fight still unwon? Let us accept the moralist, the sociologist and the suffragette as allies, but let them no longer take command. It is not a theory, but a condition—a dreadful condition—that confronts us, and as practical men and women we must meet it not with formulas and dreams and the propaganda of feminism, but with practical measures of public hygiene.

The methods of moral prophylaxis can be heartily supported by all parties, but there is the practical objection to the limitation of efforts to moral considerations that the spiritual uplift which will produce a race of Galahads who will lead sweet lives of purest chastity and wipe out the sexual diseases is not likely to come to pass much before the millennium. I speak, of course, with reference only to the male with his diffused and polygamous sexual instinct, the inheritance of a more primitive age, and his more ardent and importunate passion.

For the women whose inherent instinct is monogamic, and with whom all the traditions and conventions of society are repressive of these impulses, only a reasonable degree of protection and moral influence is necessary to keep the great majority of them in the right way. And for those who lead unsheltered lives amid surroundings of vice and temptation and exposure, vast good can be done by Girls' Friendly Societies, Sewing Clubs, Settlement Organizations and other religious and moral agencies for their instruction and protection. I do not believe that it is a social necessity that there should be a double standard of morals, but I fear that it is inevitable that for a long time to come, when we use the same standard, men will have a low mark and the women a high one. If we use the grading of the public school, the women will have a mark of "excellent," while the young men will only get from "poor" to "fair."

A law called the Page Law was recently enacted in New York, one paragraph of which provided for the medical examination by women physicians belonging to the Department of Health of all females convicted of prostitution and soliciting, and for the treatment of such as were found diseased in a public hospital. This modest beginning in sanitary control raised a storm of protest, principally voiced by a number of women's clubs. Their grounds of objection to this legislation are understood to have been the same that have been repeated since the time of Josephine Butler, the leader of the so-called Abolitionist Party in England, which, about 1870, succeeded in forcing the repeal of the contagious diseases act. The absolute acceptance of the claims of this party by a large number of people in America has been the principal obstacle to legislation for the control of the social evil and social diseases in this country.

(1) They claim that the medical examinations of public women are an outrage upon the modesty of the sex, and degrading to it.

(Ans.) There is a homely proverb that a rotten egg cannot be spoiled, and it is difficult to understand what injury can be done by a medical examination to the modesty of a class whose trade necessitates the abandonment of all modesty and the habitual exposure of the person for hire. Moreover, professional examinations for the detection of disease are common occurrences of everyday life, and are not to be held in the nature of an assault even when made against the will of the individual, as in quarantine inspection or the examinations of soldiers held in our own and most

other armies for the purpose of detecting venereal and other diseases.

(2) They assert that the control and regulation of prostitution by the State legalizes vice.

(Ans.) It has been the universal experience of mankind in all ages and in all nations that sexual incontinence cannot be prevented by legislation. As the proverb goes, "Men cannot be made virtuous by act of Parliament." It does not follow, however, that if the law recognizes evil and attempts to diminish the ill-results of practices which it is unable to repress that the evil is therefore legalized. To ignore the existence of evil because we disapprove it is to imitate the traditional habit of the ostrich.

(3) They assert that these examinations were worthless as a sanitary measure because disease could not always be detected, and infections would occur and be transmitted in the interval between examinations.

(Ans.) The statement of the abolitionists as to the worthlessness of physical examinations had more weight 30 years ago, when first advanced, than now, when the routine use of the microscope has greatly assisted the diagnosis of chronic gonorrheal infection, but even in the seventies the military statistics show that routine examination had great protective value. It does not require much knowledge of mathematics to perceive that even if one-third of the diseased among those examined escaped detection, the segregation and cure of the two-thirds would reduce by that much the amount of disease disseminated by the total number under regulation. Also, these examinations can be made highly educational to this class in inculcating the value of personal cleanliness.

(4) They assert that, although valueless as a means of protection, these examinations encourage vice by giving a false feeling of security against infection.

(Ans.) It is difficult to say to what extent the fear of infection is potent in preventing immorality. Those familiar with the reckless disregard of danger by young men when under the influence of sexual passion are not inclined to attach great value to it. Medical students, for example, are thoroughly familiar with these dangers, and yet are not usually observed to be more moral than other students.

(5) They declare that by the examination of the prostitute, and not of her male patron, the hygienic value of the system is destroyed, while the unity of the moral law is destroyed and a double standard of morals created.

(Ans.) These examinations are not a penalty for moral delinquency, but a practical method of reducing (for eradication is not hoped for) the amount of venereal disease. The activity of a diseased male in this direction is necessarily far less than the repeated daily activity of the public women. The examination of the male, however, desirable theoretically, is not practicable in civil life, but in armies it can be and is carried out as a necessary part of any system of prophylaxis. While undoubtedly disagreeable to modest

and refined soldiers, it is, like many other disagreeable things in life, patiently submitted to for the public good.

The statement of the distinguished head of the Society of Sanitary and Moral Prophylaxis in New York in this regard, that "the health officer of a port might as well attempt to prevent the importation of a plague-infested vessel by quarantining the infected women while permitting the infected men to go free," lacks the sense of proportion. The aim of the quarantine officer is different. It is to prevent the introduction of a single case of plague into a community which is free of it, and not to reduce the total amount of plague in the community by methods which it is recognized can never be more than partially successful. Moreover, the quarantine officer frequently adopts the policy of the venereal examiner. In passing the cabin passengers and detaining those in the steerage he singles out the class which is shown by experience to be most dangerous.

(6) Finally, it was declared that efforts at State interference with prostitution produced an increase in the clandestine practice of it, which could not be detected and rendered all measures of regulation futile.

(Ans.) The inability of relementation to control clandestine prostitution is by far the strongest and best sustained charge which can be brought against it, and in the great cities it very seriously compromises the efficiency of the system. It does not, however, follow that because a law is difficult of execution it is useless to enact it. Much of the failure is probably due to dishonesty and inefficiency in the agents rather than in the inherent impossibilities of carrying out the law. A modified system of regulation is in successful operation in Dresden and a number of other German cities, and although it is hopeless to expect that either clandestine prostitution or the social diseases can ever be completely eradicated, there is no doubt but that they can be very greatly reduced. In smaller cities and garrison towns the difficulty is not great, and any body of sanitary police which is honest and vigilant has no great difficulty in becoming entirely familiar with the professional public women, nor is there in practice any danger of mistaking honest women for members of this class by any but the most ingenious and unsophisticated.

A candid examination of the arguments of the abolitionists produces an impression of much theory and much emotion, but of nothing which is capable of immediate application to meet conditions as they exist. And meanwhile the victims of the Minotaur march in endless procession through our streets.

In my opinion, it is the moral cowardice and uninformed ignorance of the public in our American communities which is responsible for the terrible spread of the social diseases in civil as well as military life; and I believe that they are as prevalent in the one as the other. The medical departments of the military services are making earnest efforts to check these diseases by instruction and advice to the men, by physical examination of the men and

prompt treatment of those found diseased, by the encouragement of temperance in the use of alcohol, by promoting athletics and amusements to fill up the time not occupied by military duties and by instructing such men as will not be moral in the value of personal cleanliness and the use of certain disinfectants, which, used after exposure, will prevent infection. If with these agencies could be combined some form of supervision by the health officers of garrison towns over the public women, there is every reason to think that the results will be at least as good as those obtained in Prussia.

The recommendations of the Standing Committee of the American Public Health Association, adopted at the meeting at Milwaukee in 1910, were, in brief:

(1) To study the distribution and control of these like other communicable diseases.

(2) To initiate campaigns of education for the young in the biology of sex and for the mature in a knowledge of the dangers and methods of spread of these diseases. This instruction to be given by teachers, lecturers, the clergy, by the health departments through pamphlets, paid lecturers, etc., and by clubs and organizations of every sort.

(3) Health departments to recommend the enactment of laws—

(a) For the physical inspection and segregation of prostitutes.

(b) For the notification and report (by number only, if desired) of venereal cases.

(c) For physical examination of men before marriage, and that male applicants for marriage license be required in order to obtain the same to submit to examination by a duly-qualified physician to determine if they are free from venereal diseases. For keeping open free night dispensaries and maintenance of special dispensaries and hospitals for these diseases.

(d) To make it a crime knowingly to spread a venereal disease.

(4) Advocacy of temperance on account of the relationship between alcoholism and social diseases.

(5) Advocacy of personal cleanliness and venereal prophylaxis.

(6) Advocacy of early marriages.

These recommendations cover, as you will see, a great deal of ground, and I will not abuse your patience by any attempt to discuss them. The last one, for example, opens up a sociological question approaching in broadness that of the abolition of poverty, and is nearly related to another vexed question, viz: voluntary prevention of conception in the very poor, as proposed by Anne Besant 50 years ago.

Of late there has developed a movement, called "Neo-reglementation," which aims to curtail none of her legal rights as an individual, but to check the evils which result from prostitution. Nor-

way, Denmark, Finland, Switzerland and other countries have done away with inscription, casernation and segregation, yet all are trying to bring about a sanitary supervision of the prostitutes by the health authorities in order to check the spread of diseases through them. In Germany, Austria, France, etc., there is a gradual tendency to break away from the older, more purely police methods of "control," and to substitute sanitary supervision.

A fair and honest trial of the provisions of a law like the Page law would be a good beginning of such sanitary supervision, which should be administered without recourse to the police except in the case of those who resist the law. I see no reason why the same procedures of examination and treatment while in confinement should not be applied also to men receiving sentences of imprisonment.

There should be abundant facilities provided in connection with hospitals and dispensaries for the treatment of all cases in both sexes. This treatment should be compulsory for street walkers and common prostitutes, since experience has abundantly proved that they will not voluntarily refrain from the practice of their trade while diseased.

Men and women of Baltimore, the black-sailed ship is in your harbor and the victims are being gathered. It is for you to say whether you will sit with folded hands like the King Aegeus lamenting that such is the penalty of sin, or whether you will come forward like the hero Theseus to do helpful deeds. And I doubt not that Baltimore will contribute its Ariadnes, too, who will supply the clew of thread that will bring us safely out of the labyrinth of prejudices and sophistries in which the Minotaur makes his home.

A MANUAL OF PATHOLOGY. By Guthrie McConnell, M.D., Professor of Pathology and Bacteriology, Medical Department of Temple University; Assistant Pathologist to the Philadelphia City Hospital; formerly Pathologist to the St. Louis Skin and Cancer Hospital, and Bacteriologist to the Missouri State Board of Health. 12mo of 531 pages. Illustrated. Second revised edition. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1911. Flexible leather, \$2.50 net.

This book is just what it pretends to be, a manual, no more, no less; but of its kind it is away above the normal. The subject is treated as by a master, and students will find it of great help in supplementing their lectures. It is a complete little digest and brings the subject of pathology up-to-date. The arrangement is logical, the salient features of pathology are brought out, the illustrations are well executed and instructive, and the English is as simple as could be desired. As a means of quickly acquainting the student with the basic features of pathology, the book cannot be beaten.

ULCERS OF THE PYLORIC REGION—REPORT OF A CASE OF PYLORECTOMY.

By Harvey B. Stone, M.D.,

and

E. B. Freeman, M.D.,

Baltimore, Md.

THE literature for the last 10 years is rich in consideration of peptic ulcers of all varieties, and from all points of view. This general manifestation of interest in the subject suggests the report of the case herein recorded and the drawing of certain inferences from it. Besides the very important aspect of ulcers in the pyloric neighborhood presented from the viewpoint of clinical medicine and surgery, cases treated as was the one to be reported give rise to some interesting physiological questions. The most direct approach to a discussion of the whole subject may be secured by detailing the case report at once and using it as a text upon which to base the statements we wish to make.

J. S.; WHITE; MALE; AGE 46; MARRIED.

Past History.—Had been an excessive alcoholic. Otherwise negative except for great and habitual indiscretion in diet. Had some indefinite digestive disturbance for some time, but nothing suggests a history of ulcer of long standing.

Present Illness.—Four months before admission to hospital had presented symptoms of obstruction-nausea, vomiting, increasing constipation, marked loss of weight. He had lost 60 pounds. No pain, no blood in vomitus. Some acid eructation. Stools negative.

Examination.—Large framed, rather emaciated man. Evidence of loss of weight. Tenderness in epigastrium, most marked to right side. Slight rigidity of upper rectus muscle, with suggestion of an indefinite mass behind it. Otherwise the usual physical examination was quite negative.

Stomach Analysis.—Free HCL. 44; combined HCL. 46. Organic acids and salts 10. Total acidity 100. Stomach at times contained as much as a gallon and a half. Much dilated stomach. Greater curvature of stomach when inflated extended below level of crest of ilium.

Diagnosis.—Stenosis of pylorus from old ulcers, and from the great loss of weight; perhaps carcinomatous degeneration in addition.

Operation No. 1, June 1, 1911.

Exploration.—Stomach greatly dilated. Mass apparently obstructing the pylorus completely, 10 cm. long and 5 cm. in diameter; very hard; attached posteriorly by adhesions. The glands along the lesser curvature and the gastro-colic omentum were somewhat enlarged and indurated. While the desirability of re-

moving the growth was fully recognized, the condition of the patient at this time was such as to make any but the most urgent work unwise. Therefore, a simple posterior gastro-enterostomy was done, and the abdomen closed, leaving the removal of the tumor for a second operation.

Operation No. 2, June 14, 1911.

First incision having healed per primam, and the patient being much stronger, the pylorus was now resected. The mass was given a wide margin, both on the gastric and duodenal sides. The enlarged related glands were removed in a block with the pylorus, which was freed from the adhesions to the pancreas behind. The blind ends of the stomach and duodenum were closed and inverted. The gastro-enterostomy was found in good shape. Abdomen closed.

Post-operative History.—The second wound healed as kindly as the first had done, and two weeks after the second operation the patient was discharged from the hospital well and already gaining weight. Since that time he has been under the care of Dr. Freeman.

Analysis.—July 20—Quantity 60 c.c. Large amount of mucus present. Free HCL. absent. Lactic acid in large amounts. Total acidity 40. August 9—Practically same findings. Latter part of July, following an alcoholic spree, suffered severe attacks of what seemed to be acute gastro-enteritis. Unable to retain any food for about five days; 10-15 stools per day. With gastric lavage, and pancreatin and bismuth, he began to recover. Within a week he gained 21 pounds. Analysis on January 26, 1912: Amount 60 c.c. Mucus not excessive. Free HCL. absent; combined HCL. 2. Organic acid salts 2. Total acidity 38. Formol acidity 38. Tryptophane reaction marked. (Dr. E. S. Whitney.) He is now in excellent condition and weighs 200 pounds. No more diarrhea or vomiting or any other digestive symptoms.

Pathological Findings.—Numerous sections from the mass in the pylorus were made and submitted to several pathologists. The most obvious finding was a tremendous ring of dense scar-tissue, completely encircling the lumen of the pylorus and constricting it so greatly as almost to lead to occlusion. No active ulceration was found. The mucous membrane in places was suspiciously irregular in growth and arrangement; so much as to lead one of the examiners to consider it as an early cancerous change. The other pathologists, however, did not feel justified in assuming this much, and regarded the picture as that of dense fibrosis, due to the healing of old ulcer, with stenosis, but without cancerous degeneration. As a matter that seemed of great interest to us, we tried to determine whether the stomach emptied its contents entirely down into the distal jejunum, or whether any of the acid chyme regurgitated backward into the blind end of duodenum.

For this purpose a series of X-ray plates was taken after a bis-

nuth meal, and no shadow was seen in the duodenal region, while the material in the stomach and jejunum show well. So much for the facts in the case. Our commentaries will be brief as possible, and directed to the most interesting points alone.

From the internist's viewpoint, the case illustrates the certainty with which one may sometimes decide that an organic lesion of the stomach is present, and the difficulty in definitely diagnosing its exact pathological nature. In this particular case there was no doubt that some mechanical obstruction to the pylorus existed, and hence the only reasonable treatment was mechanical or surgical. His great loss of weight suggested that the stenosis was of a malignant nature, but the pathological findings disproved this supposition. Starvation alone was probably the only factor concerned in the emaciation. But while in this particular instance no one would be apt to question the propriety of surgical intervention, there are many less clearly cut cases that should be similarly treated. In our opinion, any stomach condition which suggests one of the surgical lesions—ulcer, cancer, obstruction, etc.—that persists in a person of middle age or over, in spite of medical treatment for a reasonable length of time, should be explored. This general statement will perhaps be generally concurred with, but the interpretation put on a reasonable length of time will vary. To our minds, a reasonable length of time, while differing with the case, of course, is a short period. In this case it was less than a week. In any case it should not be more than a couple of months, and may be as little as a few days. To the surgeon the indications, if only those of stenosis and starvation, are sufficiently clear to make an exploratory laparotomy an easy decision. The difficulty is in selecting the wisest procedure after the exact nature of the lesion is discovered. In this discussion we shall limit ourselves to a consideration of cases like our own, realizing that while all peptic ulcers have certain features in common, much that we may say about this case may not apply to ulcers differently situated. In our case two chief factors had to be dealt with—first, the lesion itself; second, the mechanical effects of the lesion. The second problem is the more urgent. Here is a man whose stomach cannot empty itself, and who is starving.

Whatever the nature of obstruction, the first indication is to restore the patency of the gastro-intestinal canal. Practically there are two ways of doing this—by enlarging the obstructed pylorus, of which methods the Finney pyloroplasty is the best example, or by short-circuiting the obstacle, as by one of the various modifications of the gastro-enterostomy. At this point one is forced to consider the second of the factors named above—the nature of the growth. Obviously, if the obstruction be of certain types, for example a malignant tumor, the fundamental principles of surgery would preclude the division and plastic closure of the stenosis required in all pyloroplasties. On the other hand, gastro-enterostomy as a treatment for ulcers of the stomach with no other direct attack upon the lesion is losing recently some of the vogue

it has enjoyed. More and more cases of recurrence of symptoms, and indeed of the ulcers, after apparent cure, are being reported in the literature. Thus Burk (1), in a very recent paper, states that he finds recurrence of ulcer in 20 per cent. of cases after simple gastro-enterostomy. We are here presented with a difficulty that neither of the commoner methods of operative treatment fully meets. In brief, a more direct attack on the lesion is needed. This is borne out by the recurrence of the trouble already referred to, and also by a more serious finding that has of late been assuming greater and greater import. We refer to the relation between ulcer and cancer of the stomach. This relation has been forcibly pointed out by Rodman (2) of Philadelphia, who has collected the experience of many writers on the subject. From among the many striking figures presented in this paper we quote the following percentages of connection between ulcer and cancer in the clinics of some of the world's leading stomach surgeons: W. J. Mayo, 54 per cent. of cancer preceded by ulcers; Moynihan, 72½ per cent.; Mayo Robson, 59.3 per cent. In the experience of the last-named operator, four cases of ulcer treated by simple gastro-enterostomy died within one to four years from cancer of the stomach. From the brief analysis of the problem just made one is led to the theoretical conclusion that the logical attack consists, first, in the removal of the lesion itself, and secondly, in the re-establishment of the continuity of the gastro-intestinal canal. This view has already gained strong advocates, most prominent of whom is perhaps Rodman. Granting the correctness of this opinion, the practical application of it must differ in response to the needs of individual cases. In our case what was required was, first and most urgently, relief of obstruction, and secondly, removal of the offending mass. To meet this requirement we felt that no course was so well adapted to our needs as a "Billroth Number 2," which is essentially the operation, done in two stages, that we have here reported. This is not the place to discuss technical difficulties and the steps of operation. Recently a good deal has been written on the handling of the duodenal stump and other related subjects. Without desiring to minimize the importance of such problems or to deny the reality of the difficulties described, we believe that these are problems of technique alone that differ with each case, and with each surgeon's resourcefulness, and do not affect the general principles before delineated—that the logical procedure is the removal of the lesion and the reconstruction of the alimentary canal, rather than the simple side-stepping or short-circuiting of the obstruction.

Before concluding this paper there are certain physiological aspects of the subject of such interest that they demanded at least a brief mention. In the post-operative care of this case we were much interested in following the gastric analysis, and also in tracing the new course of food with radiographs. The most striking thing in these studies was the persistent and apparently permanent absence of hydrochloric acid after resection of the pyloric end of

the stomach. This fact has several aspects of great interest. The work of Bayliss and Starling demonstrated that the normal stimulus for the secretion of pancreatic juice was formed by the passage of acid chyme down over the duodenal mucosa, with the formation of acid secretin. In the same experiments it was shown that the jejunum possessed the same property. But in our case, although the jejunum receives the gastric contents, there is no HCL. present. Yet obviously this man, who has gone back to his normal weight of 200 pounds from 140, must be enjoying nearly normal pancreatic digestion. The only suggestion we have to make is that the organic acids and acid salts now found in his stomach are supplying the place of hydrochloric acid in secretin production. From a therapeutic standpoint, the absence of acidity has a certain interest also. If it be true that hyperacidity is the cause or an important factor in the cause of peptic ulcer, this case need never fear a recurrence of that trouble. Also, there would seem to be no danger here of the round ulcer of the jejunum which has at times been described after such operations as this, since these ulcers are attributed to the pouring of acid stomach contents over the jejunal mucosa. In short, this patient presents the result of what a German writer called the "internal therapy of hyperchlorhydria." We are not quite sure why the gastric reaction has reversed from hyperacidity before to anacidity after the operation; the most probable explanation is that there is some regurgitation of alkaline bile and pancreatic juice into the stomach, for the part of the stomach excised was not that which gives rise to hydrochloric acid. The present function of the stump of duodenum above the gastro-jejunostomy is also a matter for curious speculation. We thought perhaps some of the food material might pass into this cul-de-sac, but from the X-rays taken and interpreted by Dr. Baetjer it appears that the duodenum remains empty during the passage of food out of the stomach. From this it would appear that the duodenum now functions simply as a duct, through which the mixed bile and pancreatic juice, with its own secretion, is conveyed to the food material in the jejunum.

(1) W. Burk: *Beitrag zur klinische Chirurgie*, December, 1911, LXXVI, No. 3, p. 545.

(2) W. L. Rodman: *Surgery, Gynecology and Obstetrics*, 1908, Vol. VI, p. 657.

THE STORY OF A DOCTOR'S TELEPHONE—TOLD BY HIS WIFE. By Ellen M. Firebaugh, author of "The Physician's Wife." Boston, Mass.: The Roxburgh Publishing Co.

Every physician is aware of the number of humorous incidents which pass over his telephone. The present story is based on some of these happenings, and to anyone imbued with a sense of humor will give a pleasant hour or so of reading.

REPORT OF PROGRESS.*

By Prince A. Morrow, M.D.

(CONTINUED FROM APRIL NUMBER.)

CONNECTICUT SOCIETY OF SOCIAL HYGIENE.

During the last two years the society's membership has increased from 600 to over 800. It has published four leaflets on sex hygiene, viz.:

1. "General Statement."
2. "For Young Men."
3. "For Young Women."
4. "Information for Persons Having Venereal Disease."

Over 60,000 copies of these were distributed. Some of the leaflets have been translated into Italian, French and Polish. Every physician of the State has received copies of leaflets No. 4 for distribution to his patients. One thousand copies of the report of the New York Grand Jury in "the white slave traffic" have been distributed. One thousand copies of the series of educational pamphlets published by the American Society of Sanitary and Moral Prophylaxis have been distributed free or by sale. A large number of the various approved books on sex hygiene have been sold, and many of these books have been lent to people unable to buy them, after the manner of a circulating library.

The society has established over 20 local educational committees in the various towns of the State, and these committees have been responsible for over 100 lectures on the subject of sex hygiene.

THE TEXAS STATE SOCIETY OF SOCIAL HYGIENE.

The society has published some booklets. The work so far has been educational and in co-operation with the State Medical Association and the women's clubs throughout the State. The society is actively and successfully engaged in the introduction of the teaching of sex hygiene into the schools, colleges and universities of the State. "We are dealing with the larger question of race culture, and, of course, show the relation of the venereal peril to this question."

NEW JERSEY SANITARY ASSOCIATION.

This society, recently organized, has made arrangements for holding meetings in different parts of the State to arouse enthusiasm and induce men and women to join in the effort to control the spread of social diseases. The first of these meetings has been arranged in conjunction with a section of the Mothers' Congress of the State, which is interested in child welfare and infant mortality.

SEATTLE SOCIETY OF HYGIENE.

Too recently organized to report active work.

*Read at the meeting of the American Society of Sanitary and Moral Prophylaxis, February 8, 1912.

THE MEXICAN SOCIETY OF SANITARY AND MORAL PROPHYLAXIS OF
VENEREAL DISEASES.

This society was inaugurated under the auspices of the Academy of Medicine of Mexico.

The society's first step was to start the magazine, "The White Cross," with the object of putting into popular form information on the dangers of syphilitic-venereal diseases to the family, society and the nation.

It published and distributed widely Dr. Fournier's pamphlet called "For Our Sons When They Are Eighteen Years Old."

An interesting original work by Mr. Roumagnac entitled "Regulated Prostitution: Its Inconveniences, Its Inutility and Its Dangers" was read and discussed in several meetings.

On the society's initiative the Spanish Benevolent Society established a free clinic for syphilis and blennorrhagia, and the School of Jurisprudence inaugurated a series of lectures for the young students.

On the society's initiative the serious and reputable journals began a campaign against the pornographic press which gave timely, good results.

At the society's request permission was given by the Department of Public Institutions and Fine Arts to hold lectures in the night schools for adults, in the normal schools for teachers and in the manual schools for men and artisans. This work is now in progress.

As a result of a discussion whether venereal and syphilitic diseases should be a legal bar to marriage, the society has placed before the Revisory Committee of the Civil and Penal Code the necessary proposed reforms, and the committee has the matter under consideration.

I have read only the more salient features of these reports to indicate the various directions in which this work is expanding, the agencies utilized and the methods which have been employed.

I may now refer briefly to the influence of our propaganda in creating a public sentiment in favor of this work, especially in enlightened centers.

It was recognized by those who inaugurated this movement that in the prophylaxis of a class of diseases which both social sentiment and professional ethics have always united to cover up and conceal, the first and most essential condition was that the public should recognize their existence and understand their significance. The keynote of this campaign was sounded as—education of the public. The chief features of this educational policy have been publicity of the extent and dangers of venereal diseases and sex instruction.

What are some of the most apparent and at the same time the most significant signs of progress in this field?

1. The change in the spirit and practice of the medical profes-

sion in sharing its knowledge with the public—the break with the policy of silence and concealment. It may be fairly claimed that this society was the first to bring the discussion of these diseases into the open, to pronounce their names before mixed audiences of men and women, and to place the class of infections on the same plane of publicity as other infectious diseases dangerous to the public health.

2. The change in the attitude of the public toward the sex problem. We find that the present day is marked by an open-mindedness on the part of the public, a receptivity to the knowledge of the facts which furnish motives to this movement, an intelligent recognition of the significance of these facts, which is in striking contrast with the indifference, the apathy and the hostility, even on the part of the public, which formerly prevailed. In many social circles this formerly forbidden topic is now discussed with a frankness, a candor and a competence which has never before been known in social history.

3. Among the most encouraging signs of progress is the change—I might more truly say the revolution—in pedagogic and social sentiment toward the question of the introduction of sex teaching in schools and colleges, as well as in the home. This society has always regarded the instruction of young people in the laws of hygiene and sex as the most important and valuable feature of its educational program, and also the most difficult, as it ran counter to deep-seated convictions and prejudices fortified by generations of heredity and training. It is gratifying to report that a wide breach has been made in this wall of conventional prejudice.

Those of you who were present at the joint meeting of this society with the New York Association of Biological Teachers in October last will remember with what practical unanimity the question of introducing sex teaching in schools and colleges was accepted as constituting an integral part of a rational education. It was so definitely accepted that it was deemed superfluous to discuss its importance or practicability; the only question was one of matter and material. The number of "Social Diseases" containing the papers and discussions at that meeting was recently sent to 1200 presidents of colleges and universities, and to superintendents of public education with an accompanying letter, asking their opinion relative to—

1. The importance of educating young people in the physiology and hygiene of sex.
2. The practicability of introducing sex teaching in schools and colleges.
3. The matter and method of the proposed instruction.

Within the few days that have since elapsed, nearly 250 replies have been received. With few exceptions, there was the most unqualified endorsement of propositions 1 and 2.

The need of such teaching is pronounced "imperative," "vital,"

"indispensable." "The most vital question civilization has to answer. When rightly answered, a number of other difficult social problems will have become non-existent." "Its value cannot be overestimated." "Of the most vital importance to the physical as well as to the moral and spiritual uplift of the race." "Such education is the surest safeguard of youth." "An intelligent and reverent understanding of sex will cleanse the world of the defective conditions of humanity physically, morally and spiritually. Many a life is wrecked because of the ignorance of these vital principles of physiology and hygiene. Many a human being spends a life that is worse than torment because he has not received the right instruction," etc.

In reply to question three, there was generally expressed some doubt as to the wisdom or expediency of introducing this teaching until the problem of the subject-matter and methods of such instruction and the age at which it should be given had been worked out, and teachers had been prepared to do this teaching wisely and effectively.

This practically unanimous endorsement of the teaching of sex in schools and colleges was a revelation and a surprise. Seven years ago scarcely an educator in this country would have had the courage to lift his voice in favor of such a radical innovation upon our established system of education.

As stated in the report of the Spokane Society, the Board of Education of Washington has made sex teaching mandatory in all the normal schools of that State. No student in one of these schools can apply for a certificate or diploma who has not completed a full course in this department.

A collective investigation which is now in progress, but not yet completed, undertaken by a committee of the National Education Association, shows that in 138 schools and colleges in this country personal and sex hygiene is systematically taught. The subject is reported as "required" in 55, "elective" in 15, and in 66 there was no specific reply to the question. In 88 schools classes are separate, in 23 mixed. Physical examination is required in 87.

4. Public sentiment is undergoing a change in reference to the treatment of the problem of the social evil. Many years ago I voiced the sentiment of many students of this problem in stating that we would never deal rightly or effectively with the social evil until we recognized that the prostitute is not so much a culprit or criminal as a victim of bad social and economic conditions. In all measures dealing with the social evil the woman has been regarded as the chief offender against morality, and the responsible cause of the spread of the diseases of vice. No one can study the unilateral measures which have been employed without reaching the conclusion that relementation as a sanitary measure is a complete failure, and as a police measure a rank injustice.

The revelations made by the Chicago Vice Commission showing the appalling extent of commercialized graft as a factor in the

ruin of young girls and their entrance into a life of shame and the exposure of the economic conditions which impel so many thousands of them along the path to prostitution have placed an entirely different light upon this question. The significance of these facts has begun to penetrate the social consciousness as never before. There has developed what Jane Addams terms "a new conscience in regard to an ancient evil."

Then, too, there has been a marked change in social sentiment in relation to the toleration of public houses of prostitution. Many are asking whether prostitution is such a necessity, so indispensable a condition of our social life as has been pretended. With the sweeping away of the physiological fallacy of the "sexual necessity for men," it naturally follows that what is not a necessity for the individual is not a necessity for society, and that the State cannot be justified in tacitly tolerating public provisions for satisfying the so-called sexual needs of its men.

Public sentiment in many communities is gradually crystallizing into the conviction that in dealing with the social evil it is no longer a question of segregation in restricted localities, of repressing its open manifestations, but rather a question of suppressing all public houses of prostitution.

We are beginning to recognize that there is no worse sophistry than the historical generalization of Lecky, that the prostitute serves as the protector of the home by furnishing an outlet to the passions of men which would otherwise be directed to pure women; it is as absurd as the idea that the diseases of vice are the best guardians of virtue.

Now as to the accomplishment of the specific purpose for which this society was organized, it may be stated that there is every reason to believe that one phase of this prophylactic work has yielded most gratifying results, viz., the limitation of infections introduced through ignorance into marriage. Moreover, there is every reason to believe that the amount of immorality in young men, especially in colleges and universities, has been materially reduced through lectures and the distribution of educational literature. Persons qualified to know have expressed the opinion that immorality in the student classes in many colleges and universities has been reduced within the past three years 20 to 40 per cent.

This report of progress would be incomplete without reference to the union of the various societies in this country into a national organization, under the title of The American Federation for Sex Hygiene, which was accomplished in St. Louis some 18 months ago. Efforts have been thus far chiefly directed to placing this federation upon a sound financial basis. Five thousand dollars was raised as a preliminary fund to be expended in securing a large endowment fund which would enable the federation to begin the important work opening up before it on a broad, comprehensive basis, and to do the work in a big, effective way. Twenty-five thousand dollars a year for three years has thus far been pledged to the federation.

Book Reviews.

OPERATIVE OBSTETRICS, INCLUDING THE SURGERY OF THE NEW-BORN. By Edward P. Davis, A.M., M.D., Professor of Obstetrics, Jefferson Medical College: Obstetrician to the Jefferson Hospital; Obstetrician and Gynecologist to the Philadelphia Hospital; Consultant to the Preston Retreat; Member of the American Gynecological Society, International Congress of Obstetrics and Gynecology, College of Physicians of Philadelphia; honorary member of the Chicago Gynecological Society, Medical Society of the State of Virginia, Academy of Surgery of Bucharest, Ophthalmological Society of Egypt, etc. Octavo volume of 483 pages, with 264 illustrations. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Cloth, \$5.50 net. 1911.

Operative obstetrics, as gynecology, etc., has become a distinct specialty, therefore any work on the subject is indeed timely, as there is at present a crying need for the latest developments in that branch of medicine under one cover. Doctor Davis' work seems to meet this demand, as the field is covered thoroughly and concisely. Accepted operative procedures in obstetrics are thoroughly described, step by step, and in many instances the operation under discussion is elucidated by a series of engravings. We have nothing but praise for the book, it is well written, unnecessary superfluities eliminated, and only the meat of the question retained; it is safe and sane in tenor, therefore thoroughly reliable and dependable, and will be found useful to all classes engaged in obstetrics, specialist, general practitioner, teacher and student.

SURGICAL OPERATIONS. A Handbook for Students and Practitioners. By Prof. Friedrich Pels-Leusden, Chief Surgeon to the University Surgical Clinic and Chief of the University Surgical Polyclinic in the Royal Charity Hospital of Berlin. Only authorized English translation. By Faxton E. Gardner, M.D., of New York. With 668 illustrations. New York: Rebman Company. Cloth. \$7 net. 1912.

To the mind of the reviewer there is not the least bit of doubt that the above-mentioned volume will prove of inestimable value to the student and beginners in surgery in mastering the intricacies of operative surgery. Although some fields of operative surgery are not covered, still that which is included within the bindery of the present volume is sufficient for the purposes of student requirements. Antisepsis, asepsis, anesthesia in operation (both local and general), division and reunion of tissues, surgery of the blood vessels, operations of the extremities, including amputations, diarticulations, resections, suture of the olecranon, drainage of the shoulder joint, arthrodesis of the elbow, treatment

of Dupuytren's contraction, tapping of the various joints, etc.; operations on the head, operations on the face, operations on the neck, operations on the chest, surgery of the abdomen, and urinary and genital organs embrace a sufficiently large field to supply student and all ordinary needs. A particularly attractive feature of the work is the arrangement of the various systems into groups. Most textbooks take up the several operations as though they were entirely separate procedures, whereas this book, instead of discussing the several operations on the extremities in groups by themselves, takes up in the same section the operations done in this portion of the body. This method has the advantage that with as little expenditure of energy as possible the student is immediately made aware of what surgical procedures are applicable to the portion of the body under discussion. The illustrations, though diagrammatic, are exceptionally clear and illustrate the matter in hand excellently. Taken all in all, Professor Pels-Leusden has produced a book ideally adapted to student purposes.

HOME HYGIENE AND PREVENTION OF DISEASE. By Norman E. Ditman, M.D. New York: Duffield & Co. Cloth. 1912.

"Home Hygiene and Prevention of Disease" is replete with good advice, which is given in a plain, straightforward manner. Dr. Ditman has produced a book which will be found extremely useful in any household. It is conservative and safe in the hands of the laity. Where it is possible to employ simple remedies for the treatment of the affection under discussion the author plainly says so, but where the sufferer is down with an affection needing a doctor, the writer advises the patient to seek medical advice. The old idea that the public should be kept in ignorance concerning matters medical is fast disappearing. Public health lectures, newspaper selections on medical topics, magazine articles along the same lines, has awakened an interest in the public concerning the ills to which the body is heir. As a result the people are now fairly well educated along medical lines, which knowledge they put to good use in discriminating between a good and a poorly-prepared doctor. It is such books as Dr. Ditman's that have brought this change about. This book especially tells in a popular, non-technical vein what the public should know about disease, its prevention, nursing, and treatment. Nurses could get a great deal of information from this volume. Although the article on cancer occupies a space of less than two pages, it can well be taken as an index to the tone, character and up-to-dateness of the book. Such advice as this certainly could do only good. A large proportion of the deaths by cancer could be avoided if the cancerous condition were recognized early enough and removed soon enough. Therefore the moment a suspicious lump is observed in the breast, a sore on the lip which will not heal, indigestion which will not improve, or if there is evidence of blood from the uterus which cannot be explained by

normal processes, lose no time in seeking medical advice to get a diagnosis.

Pain is one of the most common symptoms in cancer, but do not rely on this symptom alone, in making a diagnosis of cancer, for it is sometimes absent. Do not try to temporize with X-ray and blue-light cures. You may be losing invaluable time. See a doctor as soon as possible.

The reviewer maintains that such wholesome advice as this can only do good. Such advice as this is modern, safe and sane. It is quite certain that many a man and woman whose piles are a life-long nuisance to them would be immensely relieved by a safe and simple operation for the removal of their piles.

Many subjects which one would hardly look for in a book of this character are discussed. In order to make finding easy, the subjects treated are arranged alphabetically.

No physician should have the least hesitancy in recommending it to his patients.

THE PHYSIOLOGY OF FAITH AND FEAR; OR THE MIND IN HEALTH AND DISEASE. By William S. Sadler, M.D., Professor of Physiologic Therapeutics, The Post-Graduate Medical School of Chicago; Director of the Chicago Institute of Physiologic Therapeutics; Member of the Illinois State Medical Society; The American Medical Association; The American Association for the Advancement of Science, etc., etc. Author of the Science of Living; or The Art of Keeping Well, The Cause and Cure of Colds, etc. Illustrated. Chicago and New York: A. C. McClurg & Company. Cloth. \$1.50 net. 1912.

During recent years a great wave of mental healing has passed throughout the land. People who were chronically ill, imaginary or not, sought one sort or another of a healer, and as some were benefited various schools of mental healing were the outcome. An unbiased party must admit that the neurasthenic has been benefited by suggestion, but he must also admit that cancer, tuberculosis, and a host of other afflictions to which the soul is heir, cannot be cured or benefited by processes of thought. The separating of the chaff from the wheat, and the enlightenment of the public, both medical and lay, as to what can and what cannot be expected of mental healing, the author deems sufficient justification for this book. As Doctor Sadler obviously belongs to no cult or ism, his observations are well worth serious consideration. Every aspect of mind-cure is considered, and in non-technical terms, so that the book is available to all who desire information on this subject. The psychology, the physiology and the therapeutics of the mental states are fully and plainly presented, and the latest practical methods of psychotherapy included. Those interested in this aspect of medicine will find the book very entertaining reading.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, MAY, 1912

· NOW.

As of yore, the trite adage, "An ounce of prevention is worth a pound of cure," holds just as true now in preventive health measures. Although every advance in the prevention of disease lops off the physician's income, nevertheless the better element of the profession is ever ready to sacrifice income to health betterment, and is always willing to give gratuitous advice to his patients concerning the best methods in the prevention of disease. This is as it should be, as the greatest service the doctor can be to his fellow-man is the saving of life, regardless of pecuniary returns. This financial sacrifice on the part of the medical profession speaks well of the caliber of its individual members. It is, indeed, unfortunate that the doctor has to make money to procure the necessities of life, but such is the actual case, and he must look actualities in the face, yet with the example of what money will do always before him, when it comes to increase in income or improvement in health measures, be it to the glory of the profession, it has always selected the latter course. The conscientious doctors, and most of them are, are ever willing to educate the public and employ in the prevention of disease, to their financial loss, every advance in prophylaxis of disease. This is one of the most, if not the most, important functions of the doctor, and he who fails to recognize this obligation to his fellow-man is not performing his entire duty to his clientele. The greatest necessity of preventive medicine at this season of the year is the death of the ubiquitous fly, the nasty, dirty, filthy fly, now commencing to come into his own. He has already made his appearance, and if unchecked will soon be among

us in full force. It is therefore up to the doctor to thoroughly arouse the public as to the unseen dangers lurking on the legs of this insect, and to fully ground them in its life cycle, so that they may be the better prepared to meet this pest. Of course, it is unreasonable, with the present state of public knowledge and of supposed personal liberty, to think that this insect could be entirely wiped out of existence at one fell swoop, but many communities have already proven the practicability of mitigating the fly nuisance. By organized effort these communities have clearly demonstrated that much can be accomplished in decreasing the number of flies, and in Wilmington, North Carolina, there was noted with a lessening of the fly a proportionate decrease in the number of cases of typhoid fever. Until the Spanish-American and British-South African Wars it was not fully recognized that the fly, and not the water, was the chief source of infection. Before that it was generally supposed that typhoid was entirely a water-borne affection. It was, however, during the campaign in South Africa that it was thoroughly realized that the fly was the medium of transmission of typhoid from those infected to the healthy. This came about from the fact that the water consumed by the troops had to be transported many miles, and was thoroughly examined bacteriologically before use. A number of typhoid cases developing, the source of transmission of the malady was sought, and it was soon found that the legs and body of the fly which had been in contact with the dejecta of the typhoid acted as typhoid carriers. Since this discovery more or less spasmodic efforts have been made by individuals and communities in a haphazard sort of way to eliminate the fly, but it has been only within the past few years that a systematic effort has been made to rid us of this supposedly necessary associate. Many methods have been devised for the killing of the fly, but as in most ills, so with the fly question, prevention is easier than cure. Keep your premises sweet, clean up all refuse at least once a week, for it takes the egg eight days to hatch; cover your garbage can, thereby preventing the deposition of eggs; either keep manure in a flyproof pit or soak it once a week with a disinfectant solution. Kill every fly possible. One dead female fly now means the prevention of thousands in August. Never forget for one moment that the fly is a prolific carrier of disease; therefore, screen the sick-room windows. Always remember that your neighbor's life is to a large extent within your keeping.

Medical Items.

At the last meeting of the Anne Arundel County Medical Society Dr. Harry B. Gantt, Jr., was elected censor for two years, to succeed his father, the late Dr. H. B. Gantt, Sr. The following resolutions were adopted and ordered spread upon the minutes:

WHEREAS God in His infinite wisdom has chosen to remove from our midst our beloved member, friend and practitioner, the late Dr. Harry Baldwin Gantt,

Resolved, That the Anne Arundel County Medical Society extend to the family of the late Dr. Harry Baldwin Gantt, and to our fellow-member, Dr. Harry Baldwin Gantt, Jr., the sympathies of the members of the Anne Arundel County Medical Society in their hour of affliction and distress.

Resolved, That a copy of these resolutions be sent to the wife of the late Dr. Harry Baldwin Gantt.

Resolved, That a copy of these resolutions be sent to Dr. Harry Baldwin Gantt, Jr.

Resolved, That a copy of these resolutions be published in *The Bulletin of the National Chirurgical Faculty of Maryland*.

Resolved, That a copy of these resolutions be published in the MARYLAND MEDICAL JOURNAL.

Resolved, That these resolutions be entered upon the minutes of this meeting, held this 9th day of April, 1912.

LOUIS B. HENKEL, JR.,
Secretary.

THE engagement is announced of Dr. Thos. Rodney Chambers, son of Dr. John W. Chambers, and Miss Martha Virginia Sisson, both of Baltimore.

DR. H. ARTHUR MITCHELL has been elected president of the Cecil County Medical Society; Dr. Ernest Rowland, vice-president, and Dr. Howard Bratton, secretary and treasurer.

THE annual meeting of the Medical and Chirurgical Faculty of Maryland was held in their building, at 1211 Cathedral street, April 23, 24 and 25. The following officers were elected for the ensuing year: President, Dr. Archibald C. Harrison; vice-presidents, Drs. C. F. Davidson of Easton, J. Staige Davis of Baltimore and E. B. Claybrook of Cumber-

land; secretary, Dr. John Ruhrah of Baltimore; treasurer, Dr. William S. Gardner of Baltimore; trustees, Drs. John W. Chambers of Baltimore and William J. Todd of Mount Washington; delegate to A. M. A., Dr. Hugh H. Young; alternate, Dr. W. R. Stokes, both of Baltimore; councillors, Drs. Guy Steele of Cambridge, Josiah Bowen of Mount Washington and David Street of Baltimore; trustees Finney Fund, Drs. J. M. H. Rowland (one year), J. B. Bloodgood (two years), Samuel T. Earle (three years), W. W. Russell (four years) and Harry Friedenwald (five years), all of Baltimore; re-elected members State Board of Medical Examiners, Drs. Herbert H. Harlan of Baltimore and J. McPherson Scott of Hagerstown.

DR. T. J. CONREY of Chesapeake City, Md., has been appointed secretary of the Cecil County Board of Health.

DR. J. BURR PIGGOTT, formerly of Baltimore, is now located at 1400 M street N. W., Washington, D. C.

DR. MARSHALL B. WEST of Catonsville, Md., is ill with pneumonia.

THE physicians of Baltimore who are also musicians have formed a musical club, and made their debut at the recent meeting of the Medical and Chirurgical Faculty. Dr. Chas. F. Nolen is director of the orchestra and Dr. B. Merrill Hopkinson of the chorus. The members of the orchestra are: Violins, Drs. A. P. Herring, Martin Hanna, F. Hazellhurst, Jr., H. L. Whittle and Leo J. Goldbach; 'cello, Dr. Shepherd Drain; bass viol, Dr. Oscar Benson; flute, Drs. William J. Rysanek and Percy Wade; cornet, Drs. S. R. Wantz and Roscoe G. Cross; trombone, Dr. H. W. Stoner; piano, Dr. C. N. Branin, and drum, Dr. W. R. Dunton. Chorus—Tenors, Drs. H. H. Arthur, J. W. Cole, William R. Dunton, Jr., C. R. Foutz, Joseph E. Gichner, S. R. Wantz, H. L. Whittle and A. K. Bond; basses, Drs. B. Merrill Houkinson, Martin Hanna, J. F. Hempel, Hubert C. Knapp, William Lewis, William B. McDonald, G. Lane Taneyhill, Jr., John Girdwood and Charles H. Beeten. Mandolin, Banjo and Guitar Club—Mandolins, Drs. W. M. Carmine, Albert Keidel, H. McCarty and H. L. Whittle; guitars, Drs. Fred A. Conradi, William B. McDonald and C. N. Gabriel; banjo, William R. Dunton, Jr.; 'cello, Dr.

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- - -

BALTIMORE

Shepherd Drain, and flute, Dr. Charles F. Nolen.

DR. JOHN J. ABEL has been elected a member of the National Academy of Sciences.

DRS. W. C. LYON, E. S. Gaither, Henry Barton Jacobs, John H. King and J. T. MacCurdy are traveling in Europe, and Dr. Frank W. Pearson has just returned home from a trip abroad. Dr. Jacobs will attend the Tuberculosis Congress in Rome.

THE Legislature has appropriated \$100,000 for new buildings at the State Tuberculosis Sanatorium, Sabillasville, Md.

THE Washington County Hospital Association has remodelled the old Kee Mar College buildings and converted them into a model hospital at a cost of over \$15,000. The hospital was opened April 1. It has forty beds.

DR. THEODORE WORRALL is quite ill at his home at North East, Md.

A PORTRAIT of Dr. Eugene Fauntleroy Cordell was presented to the Medical and Surgical Faculty of Maryland at its annual meeting in April.

DR. JOHN T. O'MARA is recovering from the effects of an operation for appendicitis recently performed on him at St. Joseph's Hospital.

MARRIAGES.

WILLIAM CUTHBERT LYON, M.D., University of Maryland, '07, of Baltimore, to Miss Bella Eleanor Flaccus of Ben Avon, Pa., at Ben Avon, April 12, 1912.

BENNETT F. BUSSEY, M.D., University of Maryland, '84, to Miss Katherine M. Craig, both of Texas, Md., at Baltimore, April 25, 1912.

MAURICE D. KEFAUVER, M.D., Baltimore Medical College, '04, to Miss Bertha D. Brenner, both of Smithsburg, Md., April 11, 1912.

DEATHS.

JOHN EVANS MACKALL, M.D., University of Maryland, '08, at his home in Elkton, Md., after a three weeks' illness of typhoid fever, April 4, 1912, aged 29 years.

DAVID THOMAS BOWDEN, M.D., University of Maryland, '89, at his home in Paterson, N. J., March 18, 1912, aged 46 years. Dr. Bowden was chief surgeon in the Orthopedic Department of the Paterson General Hospital.

WILLIAM T. ARNOLD, M.D., D.D.S., University of Maryland, '75, at his home in Baltimore, March 31, 1912, of heart failure, aged 67 years.

WILLIAM H. FEDDEMAN, M.D., University of Maryland, '88, of 118 Hawthorn road, Roland Park, Md., died at the Northampton Court Hotel, Baltimore, April 12, 1912, from the effects of an overdose of chloroform. Dr. Feddeman had been in failing health for several years.

FLOYD W. ROGERS, M.D., University of Maryland, '02, of Wickford, R. I., died at the Newport (R. I.) Hospital March 26, 1912, aged 52 years, following an operation for wiring a fractured hip.

MARLEY MILFRED LOCKWOOD, M.D., College of Physicians and Surgeons, '96, at his home in Colusa, Cal., April 2, 1912, of nephritis, aged 45 years.

CHARLES E. MOORE, M.D., College of Physicians and Surgeons, '83, of McKeesport, Pa., died at a hospital in Pittsburgh, Pa., March 23, 1912, aged 57 years.

MARY LOIS JONES, M.D., Woman's Medical College of Baltimore, '01, at St. Francis Hospital, Pittsburgh, Pa., March 17, 1912, aged 35 years.

CALEB COLUMBUS CONWAY, M.D., College of Physicians and Surgeons, '86, at his home in Garard Fort, Pa., March 16, 1912, aged 64 years.

JOSEPH NEWTON LEWIS, M.D., College of Physicians and Surgeons, '92, of Roanoke, Va., was killed in an automobile accident near Roanoke, April 6, 1912, aged 44 years.

LOUIS W. CRAMPTON, M.D., University of Maryland, '69, Colonel M. C., U. S. A., died at San Bernardino, Cal., April 12, 1912, aged 63 years. Dr. Crampton had been a member of the Army Medical Corps since 1875.

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REMARKS OF THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY AT THE ANNUAL MEETING.

IN ABSTRACT.

IN his opening remarks the President, Dr. Hugh Hampton Young, referred to the great progress that has been made in procuring important public health legislation during the past few years. He pointed to the fact that previous to that time the condition of the insane in this State was in many counties deplorable, as they were confined often in almshouses, jails and places utterly inadequate. Two years ago the Lunacy Commission, of which Dr. Young is the president, first secured the enactment of a law for the State care of the insane, and secured a bond issue for \$600,000, with which buildings were built at various asylums, and a new hospital for the negro insane started. Through its efforts again the Legislature of 1912 passed an additional bond issue of \$800,000, which is thought to be sufficient now to put the whole State of Maryland on the State care basis, by providing a new hospital on the Eastern Shore of Maryland, and increasing the other hospitals which already exist. The securing of these very important legislations, after years of struggle, is to be considered one of the brightest pages in the medical annals of Maryland. He also called attention to the fact that the condition of the tuberculous of Maryland had received excellent attention by the lawmakers; a splendid sanatorium having been provided for the treatment of incipient cases, and its further usefulness provided for by additional considerable appropriation by the last Legislature. The city of Baltimore was about to begin a hospital for more chronic cases, and had instituted the visiting nurse system, which had already brought wonderful results. The State Board of Health had also accomplished great things by its educational work, and by the distribution of sputum cups and other material for house disinfection. The last Legislature had also greatly assisted the State Board of Health by the passage of several very important laws, one of which was for the improvement of a

collection of vital statistics which will now place Maryland in the front rank in this regard. The increased appropriation will also make it possible to establish a department of sanitary engineering; to increase the tuberculous work, and also the milk inspection. Altogether the State Board of Health has received substantial increases in appropriations, and should be able to do much better work. Unfortunately, a fight by the commercial interests prevented improvement in the pure food law, and also in an increased appropriation.

Dr. Young referred to the great activity of the constituent societies of the Medical and Chirurgical Faculty, which have had, in the past year, a very satisfactory career. The recent public health conference of the Medical and Chirurgical Faculty was a very great success, extending over a period of one week, during which, at night, celebrated lecturers were secured to talk on various public-health problems to large audiences. During the day demonstrations were made by numerous physicians of a splendid collection of public-health exhibits which had been brought together in the various rooms of the Faculty building. Particularly exhaustive and inspiring was the exhibit of the United States Public Health and Marine Hospital Service, who kindly sent one of their members to remain in Baltimore during the week to make the demonstration.

The exhibits on bubonic plague, tuberculosis, typhoid fever, etc., were extremely graphic and most interesting, and large numbers of people came and seemed to learn so much from these exhibits that before the end of the week was over it was decided to continue the public-health exhibits for two weeks longer, during which time arrangements were made to have the public schools alternately send large groups of children for instruction. The *Baltimore Sun* very kindly offered to publish essays by these children, and prizes were offered, for which a great many essays were written by the pupils of the various high schools, and a most spirited rivalry arose among them. Publication of these essays in the papers have done a great deal of good and excited much interest.

The Legislature was greatly impressed with this work and appropriated \$5000 for its continuance during each of the next two years.

Dr. Young also called attention to the development of a clinical laboratory for the physicians and members of the Faculty, and two splendid post-graduate courses in clinical laboratory work, which are now going on, and which were given by the various men connected with the schools in Baltimore, and which were largely attended by the physicians. Dr. Young referred to the organization of a medical orchestra and glee club among the members of the Medical and Chirurgical Faculty, which had arranged to give a musical program at the smoker on the following evening.

The scientific program was then begun, the opening paper being given by Dr. Young on some advancement in endo-vesical

surgery. After calling attention to the fact that the first ureter catheterization in the male was done by his predecessor, Dr. James Brown, with the first Brenner cystoscope, which had been discarded by Brenner as being impossible to effect catheterization of the ureters with, Dr. Young spoke of the great advancement which had been made in the past 15 years in endo-vesical work. He referred more particularly to his own work, demonstrating various instruments which he had devised to accomplish different endo-vesical operations, and mentioning in detail cases upon which they had been used. He had used his cystoscopic rongeur in removing foreign bodies. One was a case in which four calculi were found attached to sutures in the anterior wall of the bladder. These calculi varied in size from 5 mm. to almost 1 cm., but were easily removed with the rongeur through the urethra, and the sutures were afterwards also pulled out in the same way. Several cases of vesical diverticula, with calculi in them, were also reported, in which the cystoscopic rongeur was used first to enter the diverticulum and then grasp the stones and remove them. An interesting case of incarcerated ureteral calculus was reported in which the stone had been removed with the rongeur. A cyst of the prostate, which was about the size of a pecan nut, was removed from the anterior margin of the prostate with the same rongeur, and several small median prostatic pedunculated lobes were shown which also had been removed with the rongeur. Dr. Young said the instrument was of particular value in securing specimens of tumors of the bladder for microscopic diagnosis, and also for the operative treatment of certain small vesical tumors.

He next showed his urethroscopic median bar excisor, or punch, an instrument with which he had operated on almost 100 cases of various types of prostatic obstruction at the vesical orifice. The instrument is tubular, much like a posterior urethroscope, and on its inferior surface there is a fenestra which will engage the median bar when the instrument is passed through the urethra into the bladder. Within this there is a cutting inner tube which, when pushed forward, excises the median bar, which has been entrapped in the fenestra of the outer tube. The whole thing is done under the inspection of the eye, with a light on the outside furnishing the illumination. The operation can be done under cocaine, is extremely simple and painless, and practically free from danger. There has been no mortality in about 100 cases. It has been used in cases of contracture of the neck of the bladder, small prostatic lobes, imperfect results after both perineal and suprapubic prostatectomy, and small papillomatous conditions around the prostatic orifice associated with vesical calculus, and also with certain inflammatory conditions.

The third instrument which Dr. Young demonstrated was his cystoscopic evacuating lithotrite. This instrument was shaped much like the ordinary Bigelow lithotrite, but was made hollow

so that evacuation could be done through its interior, and through this same tube a long cystoscope has been constructed so that when the operation was apparently complete the cystoscope could be introduced and careful search made for the last fragment, which had been the *bête noire* of litholapaxy in the past. A special light evacuator had been constructed which could be attached to the nozzle which was contained within the outer handle of the lithotrite. By means of a simultaneous evacuation and crushing done by an assistant and the operator it is possible to greatly facilitate the operation by sucking the fragments in between the jaws and crushing them there. The instrument was thought to be one that would lead to very great improvement in the operation of litholapaxy. About 15 cases were reported in which it had been used. Dr. Young referred, also, to other great advantages in endo-vesical surgery, which he said had a brilliant future ahead of it.

THE IMMEDIATE CARE OF THE INJURED. Second Revised Edition. By Albert S. Morrow, M.D., Adjunct Professor of Surgery in the New York Polyclinic; Attending Surgeon to the Workhouse Hospital and to the New York City Home for the Aged and Infirm. Octavo of 354 pages, with 242 illustrations. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, \$2.50 net.

The corrections and additions in the present volume increases its usefulness materially, thus enabling it more thoroughly to fulfil its mission, namely, a reliable guide for those who wish to learn to meet surgical emergencies. The author covers the subject thoroughly, thereby making a book which should have a wide field of usefulness. One is impressed with its practical tone and reliability, and believes it is written in sufficiently simple and non-technical style to render its contents perfectly plain to any intelligent layman. The time has passed when the physician can bamboozle the public in matters medical. Through the lay press and otherwise the populace is becoming every day better informed concerning medical and surgical practices. If such is to be the case, better a thousand times that the material which falls into their hands shall be thoroughly trustworthy and by a reputable member of the profession. Such is the present edition of Morrow's "Immediate Care to the Injured," which deals in a simple manner with the anatomy and physiology of the human body, bandages, dressings, practical remedies, accidents and emergencies, hemorrhage, contusions and wounds, burns, scalds and exposure to cold, fractures, dislocations, strains and sprains, asphyxia and removal of foreign bodies, unconsciousness, poisoning and treatment, transportation of the injured and preparations in the house for an accident case. The book is nicely illustrated, and meets ideally the demands of a textbook for nurses or hospital stewards.

THE SURGICAL ASPECTS OF THE RECENT EPIDEMIC OF THROAT INFECTION OF UNUSUAL TYPE.

By A. C. Harrison, M. D.

IN order to obtain an approximate idea of the effect of the recent epidemic of streptococcic sore throat upon surgical conditions, I addressed a series of questions to a number of the most prominent and busiest surgeons and throat and ear men in Baltimore. These questions were tabulated so as to cover all of those conditions which have been recognized as complications arising directly from this form of throat infection.

The surgical complications of this peculiar throat infection which have been most frequently observed are these:

- Cervical adenitis,
- Otitis media,
- Otitis media with mastoid complications,
- Cerebral abscess,
- Meningitis (cerebral and spinal),
- Empyema,
- Fulminating appendicitis with diffuse peritonitis,
- Peritonitis without other local lesions.

To all the throat and ear men I addressed the following question: "Did you observe any marked increase in the number of cases occurring in your practice during the months of January, February and March, 1912, over the same months in former years, of the following conditions:

- "1. Otitis media.
- "2. Otitis media with mastoid complications.
- "3. Cerebral abscess.
- "4. Meningitis (cerebral, spinal, or both)."

To these there were nine replies. Three observers noted a definite increase in otitis media, but no increase in mastoid or cerebral complications. The other six observers note a very marked decrease. Most of these men simply state that they noted no increase. One throat and nose man appends the following note: "I do no ear work, but often see and have cases of otitis, acute or chronic, but have seen none during the past winter. I think the intense cold of last winter held in check most catarrhal conditions of the upper air passages."

One other writes as follows: "I did not observe any marked increase in the number of cases of otitis media during the months of January, February and March." On the contrary, I noted a *marked decrease* in the number of cases of otitis media, as would be shown by the much smaller number of paracentesis operations done by me this year in private practice. My experience in my dispensary service was the same as in private practice.

"I likewise saw relatively few cases of acute mastoiditis and had fewer operations than in previous years.

"I saw no cases of otitis with cerebral complications. I was called to see several cases of otitis media associated with the epidemic sore throat; these were for the most part very mild, though a few were protracted, and none developed mastoiditis.

"I have the following figures from the _____ Hospital, embracing all the cases and operations for acute mastoiditis during the first three months of 1910, 1911, 1912:

"In 1910 there were 27 cases of mastoidectomy (all private and public included in all the services).

"In 1911 there were 20 cases, and in 1912 there were 12 cases.

"In each year there was one case of thrombosis of the lateral sinus operated upon, and no case of abscess of the brain."

Another states that he had noted a marked decrease in the number of cases seen by him, both in private and dispensary practice.

Another negatives each question and notes that he has seen fewer cases of ear disease.

To the man doing the largest amount of cerebral surgery, thinking he would be most apt to see the cerebral complications, I addressed the same questions. His reply was as follows: "I have probably seen about the usual number of complications from otitis media, but so far as I am aware, no unusual ones."

It is evident from the foregoing that the recent epidemic did not increase either the number or the severity of cases of ear or cerebral complications.

To the surgeons, the following questions were addressed: "Did you observe any marked increase in the number of cases occurring in your practice during the months of January, February and March, 1912, over the same months in former years, of the following conditions:

"1. Suppurating cervical adenitis.

"2. Empyema.

3. Fulminating appendicitis with diffuse peritonitis.

"4. Peritonitis without demonstrable cause at operation."

And fourteen replies were received. Eight of these replies are entirely negative; that is, they have noted no increase in any of the conditions mentioned.

In the other six all the questions are negative except the last: "Peritonitis without demonstrable cause at operation." The replies other than negative ones are as follows:

"I have not seen any of the group of cases that you speak of."

"I have seen a number of cases of cervical adenitis during January, February and March, 1912, but only one of these suppurated and needed incision. This I considered a fairly typical case of glandular fever. I do not think that we have had any marked increase in the cases of suppurating cervical adenitis at our dispensary. I have had no increase either in empyema or fulminating appendicitis with diffuse peritonitis during these months. I have only had three cases of peritonitis without demonstrable cause at operation, due to a streptococcus, and these have all ended fatally. They were all preceded by throat infec-

tion and I considered them complications of glandular fever. These three peritonitis cases were out of proportion to the usual number of peritonitis cases without demonstrable cause which I have seen, as I have not operated upon such a case before this winter for two years. Two years ago I had a similar case due to a streptococcus."

"One case following acute tonsilitis. Result death."

"One case in consultation. Result death. One case of pneumonia with abdominal symptoms simulating peritonitis, in family where a number had sore throat with cervical adenitis. Result death."

These observations show fairly conclusively that there has been no marked increase of cervical adenitis requiring surgical intervention, and further they show that the glandular involvement accompanying this epidemic rarely suppurated, which accords with the record of similar epidemics in other places.

They also show that neither empyema nor fulminating appendicitis were observed as complications of the epidemic in Baltimore.

Only the last question: "Peritonitis without demonstrable cause at operation," is found positive, and it is strikingly so. There can be no doubt that there was a marked increase in this peculiar condition (11 cases) and its practically uniform fatality is attested by all.

In normal times such peritonitic cases are comparatively rare. A collection of this number occurring in a comparatively short space of time, leaves little question that they are closely associated with this epidemic.

In this list I might have added two cases of my own, but each of them lack specific confirmation in that no cultures were made to demonstrate the specific organism. One occurring in a middle-aged man in which there was very extensive peritonitic infection, with no obvious cause, is entirely negated by the fact that he recovered, otherwise the clinical picture is completely fulfilled. The second case was that of a child of nine years, occurring in a household where there were a number of cases of epidemic sore throat of typical picture. At the time of operation the area of peritonitis involved in this case was comparatively small. The caecum and ascending colon were much thickened and inflamed. The appendix was intact and gave no specific evidence of disease, though within its caliber there were two ulcerating areas about the size of a split pea. It progressed from bad to worse and died within the next twenty-four hours.

Two facts stand out as evident from such information as we have been able to obtain. First, that there was a marked increase in this particular type of cases; and secondly, that they are uniformly fatal. This experience has been general wherever this epidemic has occurred, and in experimental inoculation into the peritoneal cavity, death has resulted within twenty-four hours with uniform regularity.

THE MASSACRE OF THE TONSIL.*

By John N. Mackenzie, M. D.

Clinical Professor of Laryngology and Rhinology in the Johns Hopkins University
and Laryngologist to the Johns Hopkins Hospital.

DURING the past few years I have been repeatedly urged by medical friends to give some public utterance by way of formal protest against the indiscriminate and wholesale destruction and removal of the tonsils, which, far above all others, is the chief and most glaring abuse in the laryngology of the present day. They have been good enough to say that a word might not be amiss from one who has been through the dust and heat of the conflict that has raged around this and other fancies in surgical laryngology which have risen and fallen during the quarter of a century that has just passed away.

One of these friends, a distinguished general surgeon of wide experience, large practice and exceptionally high professional skill, in insisting that I say something on the subject, gave me as his deliberate opinion that of all the surgical insanities within his recollection this onslaught on the tonsils was the worst, not excepting the operation on the appendix. And, indeed, when I look back through an experience of over thirty years, in which I have seen theory after theory, for some of which I have been partially, if not wholly, responsible myself, come and go, materialize and dissolve, I feel that, notwithstanding the fact that I approach the subject with reluctance, with diffidence, with hesitancy—with even timidity, and fully mindful of the truth that we are all liable to error, even the youngest of us, and that nowadays in some quarters apparently age and experience count for nothing, I feel I may be pardoned for saying a few words in what I consider to be the interest of the public health, and, therefore, of the public safety.

Let me at the outset be not misunderstood. It is not my object to stir up strife, to impute unworthy motives to anyone, or to arrogate to myself any superior wisdom in the surgical management of tonsil disease.

Nor do I wish to shift to other shoulders all the blame. I, too, in my earlier days, have fallen by the way. Indeed, it was once facetiously said that the street in front of my office was paved with the turbinated bones of my victims.

That there are a host of conditions that call for more or less complete destruction of the tonsil is an axiomatic proposition which is not open to discussion. We have all been taking out tonsils for innumerable reasons ever since we entered our special field of work and we will continue to do so when proper occasion demands it. My contention is simply this, that in selecting our cases for operation we should be guided by a sane and safe conservatism and common sense, and not be carried away by those

*Read April 24, 1912, before the Medical and Chirurgical Faculty of Maryland.

who, by their precept and example, are fast bringing our specialty into disrepute in the eyes of thoughtful and honorable men.

Many years ago Austin Flint was conducting an examination in physiology at the Bellevue Hospital Medical School in New York. Among the students who came up for graduation was a bright young fellow to whom Flint propounded the following conundrum: "What is the function of the spleen?" And the lad replied that the function of the spleen was to enlarge in malarial fever. To the next question: "What is the function of the tonsil?" the boy declared that the mission of the tonsil was to swell and suppurate in quinsy. "That will do," said Flint, "you have passed a perfect examination, for you know as much about the subject as I do myself." Long before, a distinguished medical luminary on the other side of the Atlantic had said that were he, like Frankenstein, to attempt the artificial construction of a man, he would leave the tonsils out. In other words, at that period, or, as a matter of fact, from a period as long back as memory can run, the tonsil was regarded as a perfectly useless appendage which cumbered the throat, and which, therefore, ought to be gotten rid of. Like its little neighbor, the uvula, it was sacrificed on every possible pretext or when the surgeon did not know what else to do. I remember, a long time ago, in a discussion on hemorrhage after tonsillotomy before a New York society, a distinguished laryngologist made the statement that he had removed without accident many thousands (I have forgotten the exact number) of tonsils—to which declaration an inquisitive, incredulous individual present, with a mathematical turn of mind, said he had made a calculation which showed that in order to have removed that many tonsils within the limit of an ordinary lifetime the operator would have to average a bushel a day.

This general extirpation of the tonsils that obtained in the early days of laryngology received a rude and jarring jolt when, in the last century, it was proclaimed that the tonsil was physiologically directly related to the virility of the male. According to this luminous conception, which owed its popularity chiefly to the teachings of no less a personage than Chassaignac, destruction or extirpation of the tonsil meant impairment or extinction of procreative power. This doctrine at once made tonsillotomy very unpopular among the male laity; but when the Homeric shock of the battle that raged round this burning question had subsided, and it had been found that there were no facts to support the alleged relationship, then the work of slaughtering the tonsils again went merrily on.

But never in the history of medicine has the lust for operation on the tonsils been as passionate as it is at the present time. It is not simply the surgical thirst from which we have all suffered in our earlier days, just as at a still earlier period we suffered from the measles; it is a mania, a madness, an obsession. It has infected not only the general profession, but also the laity. A leading laryngologist in one of our largest cities came to me with the

humiliating confession that, although holding hostile views against its performance, he had been forced to do a tonsillectomy in every case in order to satisfy the popular craze and to save his practice from destruction.

Today the laity, with or without medical advice, insist on entire removal of the tonsil for almost every conceivable infirmity. If I had time to do so, I could tell you some, if they were not so serious, amusing stories in this connection.

I will only relate one. A few days ago a woman brought her little six-year-old daughter to me to know whether her tonsils ought to come out. Her nasal and throat passages were normal.

The child was in perfect physical condition and complained of nothing. I said to the mother, "Your baby is perfectly well, why do you want her tonsils out?" "Because she sometimes wets the bed."

In the annual reports of nearly all the special hospitals for diseases of the nose and throat the number of tonsil removals, as compared with all other operations on the upper air tract and its appendages, is simply appalling. In conspicuous and refreshing contrast to the usual narratives of these productions let me quote from the last report of a well-known children's hospital in this city these words of sanity and wisdom:

"A large and annually increasing number of cases apply for operation for hypertrophied tonsils, or for adenoids. Of these the adenoids practically all need and receive operation with benefit and without injury.

"The recent universal inspection of the throats of school children has revealed the fact that nearly all children at some time of life have more or less enlarged tonsils.

"That most of this is harmless if not actually physiological, and that their removal in these cases is not only necessary but injurious to the proper development of the child is our conviction.

"The rarity of rheumatism or endocarditis in children, while nearly every child has enlarged tonsils would indicate that their removal is only exceptionally advisable unless they mechanically interfere with respiration, deglutition, or speech. When this is the case they are still best removed with the tonsillotome unless radical extirpation is necessary for other reasons."

I cannot more correctly express the general attitude on the matter than by quoting the words of Professor Swain of Yale University, in the admirable paper with which he opened the debate on the subject at the last meeting of the American Laryngological Association in Philadelphia:*

"When an author speaks of his experience in upwards of 9000 cases, mentioning especially 3000 removed within the capsule within the last six or seven years, the only method which he thinks is really worth the while—he certainly has a right to speak as an expert in regard, at least, to methods. Also, it will be readily

*See Transactions 1911.

deduced that he felt in removing tonsils thus wholly he was not depriving the patients of anything important. When it is the practice in recent years of many operators all over the country to always enucleate the tonsils as completely as possible in all cases, either children or adults, as a routine procedure, it would certainly seem to argue that in general tonsils are better out than in. The question of relative size, appearance, healthiness of structure or any such matter is apparently never thought of. Remove, anyway, and dismiss the matter as not worthy of further consideration. And, again, "It is a most excellent condition of things to be operating laryngologist to a busy internist, who takes the entire responsibility of removal. Failure and success are alike credited against him, but it is a case of blissful inexactness which I consider deplorable."

Much wild and incontinent talk, for which their teachers are sometimes largely to blame, has poisoned the minds of the younger generation of operators and thrown the public into hysteria. Tonsillectomy, for example, is held out to them, not only as a sure cure for, but as an absolute prophylactic against rheumatism and heart disease. They are told that with the disappearance of the tonsil in man, these diseases will cease to exist. Parents bring nowadays their perfectly sound children to the laryngologist for tonsil removal in order to head off these affections. Tonsillectomy is recommended as a curative during the agony of acute articular rheumatism.

But the origin of the latter disease has recently been traced to an infection of the nasal mucosa following operation. Tomorrow it will come from somewhere else. Those of us who are old enough to remember will recall the story of chorea. Years ago we found the cause of this affection in the nasal passages. When this view, after the usual struggle, had to be abandoned, it was suddenly discovered that the eye was the portal of entrance. Today it has been caught in the tonsil. If we exercise a little patience it will turn up soon in some other organ.

In considering the question of operation on the tonsils, and especially complete removal, we must face the following facts:

I. The functions of the tonsil are, in the present state of our knowledge, unknown.

Whether they are portals of entrance or avenues of exit for infection, whether they protect the organism from danger or invite the presence of disease, whether the pathogenic bacteria sometimes found in them are coming out or going in, whether they are manufacturers or storehouses of leuco—or lymphocytes, whether they represent the extreme outlying protective ramparts and that, therefore, their destruction would mean the removal of the battle-line against infection from the throat to the neck lymphatics, whether the efferent current of lymph exceeds the afferent in volume or velocity, whether, which seems probable, there is an endless flow of lymph from their interior to the free surface, which, unchecked, prevents the entrance of germs from

the surface and washes out impurities from within, whether the organ possesses an internal secretion, *sui generis*, or whether, in fine, the tonsil structure is in any way essential to the well-being of the individual, are questions which have as yet received no definite solution, but which are full of interest and furnish material for instructive discussion and debate. Until the functions of the tonsil are known the final word on its removal cannot be spoken.

II. Whatever its functions may be, and the production of leucocytes is undoubtedly one of them, the tonsil is not, as is generally taught and believed, a lymphatic gland.

The general ignorance of this fact has led to the useless sacrifice of thousands of tonsils, on the fallacious assumption that their functional activity may easily be replaced by the myriads of other lymphatic glands in the body. The physiological integrity of the tonsil is of the utmost importance in infant and child life. The gland appears early in embryonic life (fourth month), attains maturity at the end of the first year of infancy, and at or about puberty tends to diminish in size. It does not develop as a lymphatic gland from a plexus of pre-existing lymph vessels in the mesothelium, but as an ingrowth of endothelium from the second branchial pouch and, therefore, in its origin must be classed with the thymus and the thyroid, the former originating from the third, the latter from the fourth, while the parathyroid takes its origin from the third and fourth branchial pouches, all by inbudding of the endothelial lining of the primitive pharynx. These anatomical facts have been recently emphasized by Gordon Wilson* of Chicago, who, in a careful study in comparative anatomy, has shown from various relations which the tonsil shows to the pharynx that the tonsil secretes or excretes a substance into the pharynx. The tonsil is present in all mammals, with a few exceptions, notably the white rat, and its anatomical arrangement is such that no matter how concealed it may be by folds of membrane it always retains communication with the pharynx. Observations made in his laboratory on the carnivora show that in this genus the tonsil is often so protected by folds as to be invisible from the mouth; but there always exists a channel of communication. This is well shown in the lion, where the tonsil lies in an elliptical sac of considerable size, which is so placed that during certain movements of the pharynx the contents may be expelled into the back of the mouth. In other words, we have here a structure which plays a role of importance in early life, in addition to its production of lymphocytes, and which necessitates a close relation to the pharynx. This role may be of infinite value to the infant in his earliest days of life, but which, as he grows through childhood into manhood, he is able to dispense with.

Now, the first organ to manufacture or store leucocytes in embryonic life is the thymus gland (Jacobi).† In view of the origin of the tonsil from the branchial pouch, is it not conceivable,

*Transactions of the American Laryngological Association 1911, p. 263.

†Archives of Pediatrics, July, 1906.

as Jacobi suggests, that it may assume the role of the thymus after birth or when the latter gland ceases to functionate or disappears?

III. It is rarely possible to separate the tonsil from its neighborhood during the acute invasion or rapid progress of a microbic or toxic poison (Jacobi).

Years ago Jacobi called attention to the fact that in cases of membranous throat disease whenever the membrane is limited to the tonsil, there is little or no glandular swelling in the neighborhood. If the membrane extends from the tonsil to its neighborhood, or starts at a distance from the tonsil, neighboring lymphatics swell at once.

Again, the treatment of this neighborhood shows its effect almost immediately in the swollen glands. This is especially true of diphtheria, which, when limited to the tonsil, produces less adenitis and constitutional symptoms, and, therefore, is less dangerous. We all remember, too, in the days before antitoxin, how much graver the prognosis was when the membrane appeared in the nose and upper pharynx than when it appeared on the tonsils. Nearly every case died.

The role of the tonsils as portals of infection, like all new doctrines in medicine, has been greatly exaggerated. To state that they are, in certain cases, the avenues through which pathogenic organisms reach other organs is simply to state an incontrovertible proposition, in the light of present-day research. But to make them responsible for the long Iliad of woes which has been laid to their account is to remove the whole question from its legitimate place in the region of cold clinical fact into the atmosphere of fads and fancies. Some absorption takes place in and from the tonsil: but it is far less than that which occurs in the more abundant and receptive lymphatic structures of the nose and nasal pharynx. The tonsil, moreover, is not built anatomically as a gateway of infection. I have not time to go into a review of this interesting subject, but will simply quote, with some modification, from a summary by Faulkner of Pittsburgh (Medical Record, July 9, 1910), based on an analysis of observations made by Most, Retterer, Labbé, Hodenpyl, Jacobi, Grober and others, and also refer you to a symposium on the subject of the nasopharyngeal lymphatics and their relation to other parts of the body by Hartz, Poli, Logan, Turner and Broekaert:*

"The faucial tonsils are peculiar organs. They possess an anatomical character different from other tonsils and other lymphatic tissues. They are innocent organs with functions chiefly confused by medical literature. Their blood supply is scant and they have almost no communication with the lymphatic system. * * * Their crypts are lined by mucous membranes having the ordinary function of other mucous membranes so far as known. They are distinctly separated from the very active absorptive and bac-

*These papers have been collected, the foreign ones translated into English, and published in the *Laryngoscope*, March, 1912.

teriolytic structures of the fauces, pharynx and nose. Their position is a segregated one. Their external deep surface is covered by a dense fibrous capsule which sometimes sends a network of fibrous tissue as outrunners along the tonsillar blood vessels (Hodenpyl), the tonsil contains a system of closed lymph canals in the follicles which do not open into the connective tissue reticulum (Retterer, confirmed by Hodenpyl), diphtheritic membrane confined to the tonsil is relatively innocent (Jacobi). There are no lymphatic sinuses around the tonsil and the nearby lymph current is less active than that of the pharynx at some distance. (Labbé), and, finally, injections made into the region of the tonsil (not even into the tonsil itself) do not spread like those made into other parts of the naso-pharynx (Labbé, Retterer, Hodenpyl, Most and Jacobi)."

Hartz,* in reviewing the important experiments of Lenhardt, says: "These experiments would lead to the assumption that the tonsils are frequently infected secondarily to acute infection of the nose and the accessory cavities and the nasopharynx. * * * It is probable that every inflammation of the mucosa induces a swelling, often imperceptible, of the neighboring lymphatic glands of greater or less extent, which, acting as a protective mechanism, inhibits the development of the germ. To the tonsils, which have the function of an open lymphatic gland, may be ascribed a protecting influence against the micro-organisms which are ever present in the mouth and nasopharynx, acting, also, as a barrier against their invasion into the trachea and esophagus. On the other hand, it must be admitted that the tonsils are frequently the seat of primary inflammation, and that they are more susceptible to disease than other membranous structures in this region."

The question has two sides, a purely bacteriological and a purely clinical one. If we consider the vast extent of the area through which infection can possibly take place, and if we follow the lead of experiment and that of the pure bacteriologist to its extreme limit and logical end, we may find that nothing short of the guillotine or the axe will insure the patient against absolute and certain immunity from infection through the throat.

On the other hand, when we consider the fact that there are constantly loitering around the oro and nasal pharynx—this region is the clubhouse of the streptococcus—a miscellaneous crowd of pathogenic bacteria, and when we consider the further fact that thousands of operations are done in these regions every day and necessarily without antiseptic precautions, is it not significant at least that we meet with so little sepsis following their performance?

The chief practical lesson to be drawn from the foregoing facts is that in cases in which the throat, and particularly the tonsils, is apparently the starting point of infection, it is mandatory to

**Laryngoscope*, March, 1912, p. 189.

examine the entire upper air tract and not be content with appearances that are visible to the eye through the open mouth alone. How many stop their search for the cause at the tonsil and fail to explore the deeper parts of the pharynx, the retro-nasal space, to say nothing of the nasal passages and accessory sinuses? This entire region must be reckoned with, and failure to do so has probably sent more than one to his grave. I know of a number of cases of fruitless removal of the tonsil which have only gotten relief when treatment was subsequently directed to the nasal cavities and post-nasal space. Not to mention many others, I am forcibly reminded of a case of general poisoning and wrecked health in a young woman in whom I had thought I had traced the source of infection to an antrum maxillary empyema. As there was no escaping pus, my diagnosis was not accepted by the family and attendant, and I was not even permitted to make an exploratory puncture. I am unable to say what operation, if any, was done, as she naturally passed out of my hands. But as she grew rapidly worse, and as the futility of the treatment became apparent, my advice was finally reluctantly and doubtfully taken, the antrum was opened, the foetid contents evacuated and the patient, under appropriate treatment, went on to speedy and complete recovery.

I could tell you, also, of cases in which the tonsil has been held responsible for the morbid condition, and has been partially or completely removed, in which relief has only been secured by the discovery and treatment of disease in the nose and retro-nasal space. And of far graver, far-reaching and deeper significance are cases of infection in which life has doubtlessly been sacrificed by clinging to the lazy and stupefying delusion that the tonsil is the sole portal of poisoning.

The hypertrophied lymphatic tissues of the vault of the pharynx (adenoids) does harm chiefly through obstruction. Restore normal respiration in the child, and in a large number of cases the tonsils will take care of themselves. Even if the glands should remain large, if they are giving no trouble, they may be safely left *in situ*, for as their growth does not go on *pari passu* with the growth of the rest of the pharynx, the time soon comes when they become inconspicuous in the fully developed fauces.

The mere size of the tonsil is of itself no indication for removal except it be large enough or diseased sufficiently to interfere with respiration, speech, or deglutition, in which case it, or a sufficient portion, should be taken away without delay. A large tonsil does not mean necessarily a diseased tonsil, nor does a small tonsil always indicate a healthy organ. Tonsils apparently diseased may consist of normal tissue and, on the other hand, perfectly normal looking glands may be found pathological microscopically. The tonsil may be greatly enlarged, may extend far down into the pharynx or be buried deeply in the palatine arcade and yet not interfere with the well-being of the individual. Such tonsils are the special prey of the tonsillectomist. If they are not interrupting

function, they had best be left alone, for they are doing no harm. The change in anatomical relations after operation is often so great that function is crippled more after their complete removal than it was before. Moreover, it occasionally happens that the resurrection of a "buried" tonsil is followed by the burial of the patient.

A most interesting and instructive part of this subject is the occurrence of tonsil disease, with or without cervical adenitis, from infection from the nasal passages. (from pus cavities, operations, etc.) and the improper care of the teeth during dentition. Wright,* of Boston, reports a remarkable series of 150 cases in which operation on the tonsils was deferred until after the eruption of the molars, not only in the six, but in the twelve-year period, and when dentition had been completely accomplished the enlarged cervical lymphatic glands disappeared, together with the swelling of the tonsils.

The practical illuminating lesson of these observations is that if, in infancy and childhood, we pay more attention to the neglected nasal cavities and to the hygiene of the mouth and teeth, we will have less tonsil disease and fewer tonsil operations.

Tonsillitis not infrequently follows operations on the nasal cavities, especially if pus be present, or even after a cold in the head. Experimental work along this line would seem to indicate that infection takes place through the lymphatics. Thus, in the carefully conducted experiments of Lenhardt,† it was found, among other things, that foreign matter, even when injected into the mucous membranes of one nasal passage, was found in both tonsils a short time after the injection.

In the permanent removal of tonsil disease equally good, and in the long run even better results may be obtained in a large percentage of cases by measures less radical than those usually employed at the present time. Out of a multitude of examples, take the case of recurring quinsy, for which complete enucleation is done. In this condition it has been found that it is frequently only necessary to thoroughly slit up and shrink the upper lobe of the tonsil. Most quinsies occur in this situation, and the destruction of that part of the tonsil is all sufficient to prevent recurrence. By this method enough of the organ is left to entirely perform its functions, and the ultimate development of quinsy of the lateral columns of the pharynx which follows sometimes complete removal is avoided.

VIII. I do not propose to enter the perennial and monotonous controversy of tonsillotomy versus tonsillectomy. Each operation has its legitimate indications and aims. I do not intend to discuss them. I will only say, in passing, that enucleation of the tonsil with even the removal of its capsule, if so defined, complete enough for all practical purposes, and this fact should be generally known, practically free from danger and with equally, and in

**Boston Medical and Surgical Journal*, May 20, 1909.

†*Archiv. f. Laryngologie*, 1909, Bd. XXI.

some instances better results, can be done with the guillotine or one of its modifications. In the majority of cases this procedure will be all sufficient. It is a much simpler method, especially in children, and it is not handicapped by the danger of complete enucleation, with its many accidents and complications, to say nothing of its long roll of unrecorded death. To subject a child to the latter operation, with all that it entails, when we have very much safer and practically just as efficient measures at hand, is, to say the least, bad judgment and unnecessary surgery.

As I see this part of the subject in the light of my own experience, and in the experience and observation of others, the truth is slowly but surely dawning, and at no distant day will irresistibly emerge into recognition that the so-called complete enucleation—the chief objection to which is that it can never be made complete—except in individuals in whom the organ is totally diseased, is an unnecessary operation in the great majority of cases in which it is at present done, and may be supplanted by many other methods which are perfectly safe and efficient and not open to its many serious objections. That the tonsil has some important mission to fulfill is furthermore shown from its frequent appearance after enucleation—a protest—as it were—on the part of nature against the total destruction of its functions, and the vicarious activity of the neighboring lymphatic tissues when its physiological properties cease to exist. This is strikingly shown in the case of quinsy of the lateral columns of the pharynx, before referred to, when the tonsil is rudimentary or gone. In the case, too, of infectious diseases whose poison is eliminated by the throat this compensatory action is most marked. Thus in the malignant epidemic of tonsillitis which occurred last year in Boston, in which the disease was not contagious, did not start from a septic focus in the throat, but was introduced through the food supply (milk), after much constitutional disturbance, the whole tonsillar ring, as Coolidge* expresses it, broke into flame at once. The patients whose tonsils had been removed did not escape the process in the pharyngeal lymphoid tissue, the constitutional symptoms or the cervical adenitis.

The tonsils are phonatory organs and play an important part in the mechanism of speech and song. They influence the action of the surrounding muscles and modify the resonance of the mouth. On the other hand, they may be so enlarged as to cripple both these functions, and should, therefore, be removed, such removal being sometimes a gain to the voice of one or more octaves. In tonsillectomy no one can foretell the amount and character of change in the anatomical relations of the parts, no matter how skillful the surgeon is or how skillfully the operation is performed. The adhesions and contractions left after this operation, even in the best of hands, lead often to deplorable changes in the quality and ruin of the singing voice. I should

*Transactions American Laryngological Association 1911, p. 272.

certainly hesitate long before advising such an operation in a great singer or anyone dependant upon the voice as a means of livelihood. The operation of tonsillectomy is a capital operation, a dangerous operation, and should only be done in a hospital or other place where every facility is at hand to meet the gravest possible emergency. It should only be done by a surgeon skilled in its performance and thoroughly equipped for every accident, and with a mind fully awake to the possible fatality which has so often followed as its result.

One word, again, to those who will fail to grasp the meaning of these remarks. It is not my object to decry in the least degree the many excellent measures which modern ingenuity has devised for the surgical treatment of tonsil affections. No one resorts to them with more alacrity than myself when the necessity for their adoption is apparent.

It is not my purpose to assail operation for definite and legitimate cause, but to warn against the "busy internist," as Swain so aptly terms him, who is too busy to waste his time with such trifles as differential diagnosis or diagnosis by exclusion, and his accommodating tonsillectomist, who, whether he admits it to himself or not, cares less about the cause of the trouble, as he is in the business for revenue only.

We who are teachers of laryngology should wake up to the responsibilities of our position and see to it that our pupils shall not leave our institutions or post-graduate schools until they are taught, on the one hand, conservatism and moderation in the surgical treatment of the simpler affections of the upper air tract, and, on the other hand, thoroughness and completeness when brought into the presence of situations of graver emergency. The problem, though difficult, is not impossible of solution. The cure for the evils I have been discussing is largely educational.

While impressing upon our students the absolute necessity for surgical measures in proper cases, we should at the same time make the dangers of their indiscriminate performance fully apparent. In this way only can we be reasonably sure of accomplishing the desired result. The error of first impression derived from teacher and textbook is often difficult of eradication. In the lecture-room in the clinic, in our daily walks with the student, let us make that first impression a good one.

But equally if not more responsible for the deplorable state of affairs which exists today in the matter under discussion, are the teacher of internal medicine and the general surgeon. When pre-eminent authority proclaims in lecture and textbook as indisputable truth the relationship between a host of diseases and the tonsil of the child, and advises the removal of the glands as a routine method of procedure, what can we expect of the student whose mind is thus poisoned at the very fountainhead of his medical education by ephemereal theory that masquerades so cheerily in the garb of indestructible fact? How are we to offset the irresponsibility of the responsible? But we hear on all sides—

"Look at the results." Results? Here is a partial list from the practice, not of the ignorant, but of the most experienced and skilled: Death from hemorrhage and shock, development of latent tuberculosis in lungs and adjacent glands, laceration and other serious injuries of the palate and pharyngeal muscles, great contraction of the parts, removal of one barrier of infection, severe infection of the wound, septicemia, troublesome cicatrices, suppurative otitis media and other ear affections, troubles of vision and voice, ruin of the singing voice, emphysema, septic (infarct) pneumonia, increased susceptibility to throat disease at the seat of operation, pharyngeal quinsy, and last, but not least, tonsillitis!

Who, may I ask, is in the better position to advise, the surgeon or practitioner, who, without sufficient knowledge, lightly recommends complete enucleation of the tonsils, or those who have devoted their lives to the study of throat conditions and who come in daily contact with its disastrous and often fatal end results? Formerly it was the nasal septum, now it is the tonsil that is the surgical objective of every beginner in laryngology, and a tonsillectomy is usually his first baptism of blood. This operation is done all over the land by operators of all kinds, and, if the truth were known, with great mortality. The amount of reckless surgery done in this field will never be known or chronicled in the pages of medical literature, but it may be found in its abiding place in the book of the recording angel.

Let us hope that the day is not far distant when not only the profession but the public shall demand that this senseless slaughter be stopped. Is not this day of medical moral preaching and uplifting a fitting one to lift the public out of the atmosphere in which it has been drugged and for the reckless tonsillectomist a proper time to apply the remedy of the referendum and recall.

We are going through today in laryngology what the gynecologist went through years ago. The ovaries were removed then under as little provocation as the tonsils are being taken out today. The so-called "tonsil question" is one of simplicity and comparatively small dimensions when viewed in the light of sanity and common sense, but it has been made to assume formidable proportions by unsound observation and reckless surgery. It has come to a point when it is not only a burning question to the profession, but also to the public. This senseless, ruthless destruction of the tonsil is often so far reaching and enduring in its evil results that it is becoming each day a greater menace to the public good. Until we have more definite knowledge concerning the use of the tonsils no one can tell the damage done to the children of the present generation or the influence of wholesale tonsil removal on the children of the next. Whatever a more exact examination of the tonsil may reveal as to its function, I believe it was placed in the throat not with evil, but with good intent—to serve a teleological rather than a pathological purpose—that its mission is physiological and that it was not designed by Nature as a natural, easy and convenient avenue of infection. It

is, of course, not open to debate that there are a multitude of conditions that call for partial destruction or more or less complete removal of the tonsils; but radical operation should not be done without definite and sufficient reasons. The tonsil should not be sacrificed any more than any other organ, without convincing evidence that it is the cause of the disease to be removed.

Hasty theory, which sees in destruction of the tonsil the only means of treatment, and which, unmindful of the lymphatic and other anatomical arrangement of the neighboring structures and their physiology, and which, losing sight of the further fact that it is hard, if not impossible, to determine during life that the tonsil is the only avenue of entrance in a given infection, throws differential diagnosis to the winds, should have no part in modern scientific laryngology. When we shall clarify the atmosphere of our ideas in this matter, and when sane authority shall demand a halt, then we will hear less of the massacre of innocent organs and have less frenzied literature on the subject.

ARMY MEDICAL CORPS EXAMINATIONS.

THE Surgeon General of the Army announces that preliminary examinations for the appointment of first lieutenants in the Army Medical Corps will be held on July 15, 1912, and September 3, 1912, at points to be hereafter designated.

Full information concerning these examinations can be procured upon application to the "Surgeon General, U. S. Army, Washington, D. C." The essential requirements to securing an invitation are that the applicant shall be a citizen of the United States, shall be between 22 and 30 years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, shall be of good moral character and habits, and shall have had at least one year's hospital training, after graduation. The examinations will be held concurrently throughout the country at points where boards can be convened. Due consideration will be given to localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

The examination in subjects of general education (mathematics, geography, history, general literature and Latin) may be omitted in the case of applicants holding diplomas from reputable literary or scientific colleges, normal schools or high schools, or graduates of medical schools which require an entrance examination satisfactory to the faculty of the Army Medical School.

In order to perfect all necessary arrangements for the examination, applications must be complete and in possession of the Adjutant General at least three weeks before the date of examination. Early attention is therefore enjoined upon all intending applicants. There are at present sixty-eight vacancies in the Medical Corps of the Army.

Book Reviews.

NEW AND NON-OFFICIAL REMEDIES. Chicago: American Medical Association, 535 Dearborn avenue. Cloth, 50 cents; paper, 25 cents. 1912.

The present edition of *New and Non-Official Remedies*, as its predecessors, contains those remedies which have been approved by the Council on Pharmacy and Chemistry of the American Medical Association. It contains descriptions and actions and uses of all articles which have been accepted by the above-mentioned Council. The first 20 pages are devoted to the official rules of the Council on Pharmacy and Chemistry, especially those governing the admission of proprietary remedies to the book. Physicians should find the present edition very useful.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. With the Collaboration of Wm. Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; Charles H. Mayo, Rochester; Thomas H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Richard Kretz, M.D., Vienna. With Regular Correspondents in Montreal, London, Paris, Berlin, Vienna, Leipzig, Brussels and Carlsbad. Volume I, Twenty-second Series. Philadelphia and London: J. B. Lippincott Company. Cloth, \$2 net. 1912.

The article contributed by J. S. Taylor, U. S. N., on "Venereal Disease in the United States Navy—Its Prevention and Treatment," demands careful attention. When about one enlisted man in every five in the year 1910 had one form or other of venereal disease, it is about time that the medical profession takes notice. According to the writer, there were an average enlisted strength in the Navy and Marine Corps in 1910 of 58,340, and of these, 1968 were treated for chancroids, 6062 for gonorrhea and 1150 for syphilis. Each year the statistics show that the venereal evil is on the increase in the branches of the military service. Leaving alone the harm to those infected, for the sower should only expect to reap what he sows, think of those who innocently contract one or the other form of venereal disease from the carelessness of the diseased. Twenty per cent. of the enlisted force down with venereal trouble is indeed a national calamity. In 1910 the medical authori-

ties came to this conclusion, and took active steps to limit the prevalence of venereal affections. The problems are manifold, and as yet remain unsolved, but the fact that the venereal curse has at last commanded the attention of the navy authorities augurs well.

The article on "Experimental Poliomyelitis," by Simon Flexner, and "The Present Status of Our Knowledge Concerning the Etiology of Pellagra," by John Funke, should both command our interest. They are both by authorities on the subjects treated, and are both burning questions of the day. After a very thorough discussion the writer concludes that neither the maize nor the gnat theory satisfactorily explains the occurrence of pellagra. The article is carefully written. Anyone interested in this aspect of medicine should certainly read it.

Besides these articles there are a number of others meriting more than passing notice, i. e., "Management of Post-Operative Period of Mastoiditis," "Surgical Anatomy of the Female Perineum," "Simplifying the Operation for the Radical Cure of Inguinal Hernia," etc.

BLAIR'S POCKET THERAPEUTICS. A Practitioner's Handbook of Medical Treatment. Based upon the most authoritative and practical methods, and a rational treatment of symptoms. Containing many means not commonly mentioned in the text-books, and a plan for the solution of the vexed question of drug dosage. By Thomas S. Blair, M.D., Neurologist Harrisburg (Pennsylvania) Hospital; Author of "A Practitioner's Handbook of Materia Medica," and of "Public Hygiene"; Member of American Medical Association, etc. Philadelphia: The Medical Council Company. 1911. Flexible leather, \$2.00 net.

This book is indeed much in little. It furnishes a condensed discussion of the best methods of treatment with well-tried formula, occasionally interspersed to illustrate the applicability of the principles. An exhaustive table of large, medium and small doses is given at the end of the book. The diseases treated are divided into related groups. The book will be found especially useful as a pocket companion, where it will always be handy for instant reference purposes.

DIFFERENTIAL DIAGNOSIS. Presented Through an Analysis of 385 Cases. By Richard C. Cabot, M.D., Assistant Professor of Clinical Medicine, Harvard University Medical School. Second edition. Revised. Profusely illustrated. Octavo of 764 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, \$5.50 net. 1912.

There is nothing like success as an index as to whether a book has met the demands of the profession. We predicted for the first volume a great success, and at that time pointed out that there

was a place for such a book as Cabot's "Differential Diagnosis." Our prediction has proven true, and a like prediction is bespoken its successor. Surely the present edition will meet, more so than its predecessor, the most exacting demands of a critical profession. The present volume is along the same lines as the former, but more thorough. Here, as in the former edition, the author lays most stress on the presenting symptoms; for instance, headache, pain, fever, chills, etc. These leading symptoms he groups into sections, and, together with illustrative cases, discusses their probable causes. Dr. Cabot has thereby made a book somewhat different from any other—a book which at a glance will enable you to ferret out the probable diagnosis of any case presenting itself for your consideration. It is, in fact, a clinical lecture without the presence of the lecturer, and from its arrangement enables the physician to avoid wading through volume after volume before he finds what he is seeking. It is a most valuable book, and should be in the library of every doctor.

DISEASES OF THE GENITO-URINARY ORGANS AND THE KIDNEYS.

By Robert Holmes Greene, A.M., M.D., Professor of Genito-Urinary Surgery, Medical Department of Fordham University; Genito-Urinary Surgeon to the City and the French Hospital, New York City, and Harlow Brooks, M.D., Assistant Professor of Clinical Medicine, University and Bellevue Hospital Medical School; Visiting Physician to the City Hospital and to the Montefiore Home for Chronic Invalids, New York City; Consulting Pathologist to the Muelenberg Hospital, Plainfield, N. J., and to the Hackensack Hospital, New Jersey. Third edition, revised and enlarged; 339 illustrations; octavo of 639 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, \$5 net; half morocco, \$6.50 net. 1912.

This excellent book has been much improved in form and substance, rendering it more than ever a valuable and practical adjunct to physicians' libraries. As heretofore, it is one of the best expositions on the subjects with which it deals, its particular feature being its practicalness. The authors seem to intuitively divine just what is necessary and what is superfluous for their readers. They have thus within reasonable limits made a book available for the demands of the general practitioner and surgeon. The reviewer is especially struck with the omission of debatable theories and the inclusion of only what has been found practical by the writers. The contents will be found to be strictly in accord with modern ideas and right up to the minute. The illustrations are well executed and well adapted to the text which they are intended to elucidate.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, JUNE, 1912

EVERYBODY'S DOING IT.

THE above caption of a popular song might truly be applied to the present trend in medical education. Everybody's doing it, doing what? Setting up preposterous standards for the medical student to meet within the period of his greatest receptibility, and demanding of him from three to four years longer preparation than is to the best interest of the community and the man himself. In the March fifteenth issue of the *American Medical Association Bulletin*, educational number, Dr. Arthur Dean Bevan makes pertinent remarks along the same lines. Dr. Bevan's statements are of such moment to the medical profession and prospective students of medicine that THE MARYLAND MEDICAL JOURNAL feels compelled to acquaint its readers with them. The paper clearly shows that the writer is an authority on medical education, for which reason those interested in medical education, especially teachers of medicine, should familiarize themselves with its import. What is necessary and what not for a student entering into the study of medicine has been the battling ground of the highly endowed and commercial schools for the past decade or more. Both are wrong, the entrance standards of one are too high and of the other too low. The one compels the student to spend the best years of his life acquiring a lot of stuff of no earthly use when he enters upon the study of medicine, thus requiring him to waste anywhere from three to four years. The writer does not desire to convey the idea that he deprecates the cultivating influence of a liberal education, the acquirement of which is very pleasant and elevating, but for those who are going to follow medicine as a life's work it throws them out upon their own responsibilities generally

at too late a period. Doctor Bevan states that a general agreement has been reached both here and abroad as to what constitutes a minimum preliminary requirement for medical study. It is: The student should possess a good primary and secondary school education. If the boy enters the primary school at six he will graduate from the secondary school at eighteen or nineteen. He should have, in addition to this, a sufficient knowledge of chemistry, physics, biology, to enable him intelligently to begin his medical studies. In Canada, England and Germany this additional preliminary training can be obtained in one year of work either in the medical school or in the science department of a university. Then follows four years of medical studies proper and a year or more of hospital internship. According to Doctor Bevan the Council on Medical Education believes that one year of hospital service should be required before the graduate is permitted to engage independently in practice.

To our way of thinking Dr. Bevan has struck the happy medium in medical education. If Germany, the recognized leader in medical thought today, can produce the men she does without such stringent requirements, there is something radically wrong with our methods. There is no doubt but that America is suffering from too much pedagogical pedantry. Non-medical educators to a large extent have set the standards, and every school not reaching is considered behind the times, run for commercial purposes, and a menace to the country. Those schools of the extremely rigid requirements in many instances have non-medical men occupying many of their laboratory chairs, or medical graduates who have never practiced. What practical knowledge has either of these classes concerning student needs? As a rule they teach pure science, and this applies especially to the non-medical teacher. The student of medicine is not after pure science; he is after what is essential and necessary for him to engage intelligently in the practice of medicine. We believe with Dr. Bevan that any system which holds its students until their average age at graduation is 26 or 27 years is imposing an unjust burden upon the student, and especially so when pecuniary returns after this long period of apprenticeship are taken into consideration. Indeed, as Dr. Bevan states, it is nothing short of a crime committed under the guise of the interests of higher education. Then, too, from the standpoint of efficiency it is undesirable.

Medical Items.

IN the May JOURNAL we stated that Dr. J. McPherson Scott was re-elected a member of the Board of Medical Examiners. Dr. Scott was a hold-over, and Dr. Franklin Buchanan Smith of Frederick was re-elected.

GOVERNOR GOLDSBOROUGH has appointed the following coroners to serve for the ensuing two years:

Central District—Dr. Thomas R. Chambers (Johns Hopkins), successor to Dr. W. T. Riley.

Northwestern—Dr. David I. Macht (Johns Hopkins), successor to Dr. Silas Baldwin.

Southern—Dr. J. Frederick Hempel (Baltimore Medical), successor to Dr. Otto M. Reinhardt.

Eastern—Dr. Elijah J. Russell (Physicians and Surgeons), successor to Dr. R. B. Keyser.

Southwestern—Dr. Michael A. Abrams (University of Maryland), successor to Dr. Herbert C. Blake.

Northern—Dr. Henry G. Algire (University of Maryland), successor to Dr. G. Milton Linthicum.

Northeastern—Dr. Robert G. Davis (Physicians and Surgeons), successor to Dr. Fred Carruthers.

Western—Dr. J. G. Jeffers (Baltimore Medical), successor to Dr. Patrick F. Martin.

At Large—Dr. Henry C. Hyde (University of Maryland), successor to Dr. Ronald T. Abercrombie.

DR. H. A. SLADE of Reisterstown has been appointed health officer of Baltimore county, vice Dr. J. F. H. Gorsuch.

DR. GEORGE B. REYNOLDS, who was assaulted by sandbaggers while returning from a night call May 18, is considerably improved. The assailants have not been found.

THE engagement is announced of Dr. Howard J. Maldeis, University of Maryland, '03, to Miss Louise Cecil Watkins of Arlington, Md. Miss Watkins has been a pupil in the University Hospital Training School for Nurses.

THE engagement is announced of Dr. Roscoe D. McMillan, University of Maryland, '10, of Red Springs, N. C., to Miss Gertrude Anne Garrison of Burgess Store, Va.

DR. CHARLES J. CAREY, the first superintendent of the Springfield Hospital, has been elected superintendent of the Eastern Shore State Hospital, which will be built in Dorchester county, in accordance with the resolutions adopted by the last Legislature.

THE following fourth-year men of the College of Physicians and Surgeons have been appointed internes at the Mercy Hospital: Richard A. Ireland, M. W. Kuhlman, Andrew A. Anderson, John F. Spearman, Harry S. Brillhart, George V. Scott, A. M. Evans, E. P. Smith, M. B. Williams and Thomas J. O'Brien. Dr. A. C. Gillis is medical superintendent of the hospital.

THE following district health officers for Baltimore county have been appointed:

First—Dr. Marshall B. West.

Second—Dr. H. F. Shipley.

Third—Dr. H. A. Naylor.

Fifth—Dr. Cyril E. Fowble.

Sixth—Dr. Joseph S. Baldwin.

Seventh—Dr. E. W. Heyde.

Eighth—Dr. B. R. Benson.

Ninth—Dr. R. C. Massenburg.

Tenth—Dr. J. T. Payne.

Twelfth—Dr. W. E. McClanahan.

Thirteenth—Dr. F. H. Ruhl.

Fourteenth—Dr. W. F. Clayton.

Fifteenth—Dr. J. W. Harrison.

The first meeting of the new officers was held in the office of the Board of Health at Towson on May 8.

MARRIAGES.

EDWARD DORSEY ELLIS, M.D., Baltimore Medical College, '90, to Miss Mary E. Stebbins, both of Baltimore, May 8, 1912, at Baltimore.

DEATHS.

EPHRAIM HOPKINS, M.D., University of Maryland, '59, at his home in Darlington, Md., May 11, 1912.

JAMES BACON, M.D., Jefferson Medical College, '65, at his home in Baltimore, April 29, 1912, of heart disease, aged 65 years.

HUMPHREY E. BOWMAN, University of Maryland, '39, died at the home of his daughter in

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- - -

BALTIMORE

Farmington, Iowa, from senile debility, April 29, aged 93 years.

JOSEPH C. BENZINGER, University of Maryland, '63, died at his home in Baltimore, May 4, 1912, of heart disease, aged 68 years.

JOSEPH NEWTON LEWIS, M.D., College of Physicians and Surgeons, '92, of Roanoke, Va., was instantly killed in an automobile accident near Roanoke April 6, 1912.

JOSIAH R. BROMWELL, M.D., University of Maryland, '71, died at his home in Washington, D. C., May 25, 1912, after a lingering illness, aged 70 years.

NURSES GRADUATE.

THE Mercy Hospital Training School for Nurses held its commencement in Loyola College auditorium May 23. The graduates were:

Maryland—Misses Rose Mary Burinsky, Barbara Agnes Boland, Pauline Lee, Martha Diehl Maslin, Virginia Maslin, Bessie McNutt and Helen Marguerite Nottingham.

Pennsylvania—Misses Clara Agnes Boyle, Mary Magdalene Boyle, Anna Mary McCann and Margaret Anastasia Duddy.

West Virginia—Misses Cora Jane Hannah and Nellie Elizabeth Sayre.

THE commencement exercises of St. Joseph's Hospital Training School for Nurses were held on May 9, 1912, in the hospital hall. The 12 graduates were:

Maryland—Misses Mary C. Grace, Margaret Wohlgemuth, May Malone, Inez Collete, Dorothy Kalben, Carolyn Youngholt, Rachel Chaney, Frances Martin and Carolyn Preller.

Massachusetts—Miss Delia Reilly.

Indiana—Miss Elizabeth Johnson.

Virginia—Miss May Ragland.

THE Hebrew Hospital Training School for Nurses sent its largest class from its halls on May 9, when the following graduates received their diplomas:

Misses Goldie M. Collins, Isabelle N. Fisher, Mary E. Minder, Mary J. Tyree, Hilda Pfefferkarn, Minnie C. Bayrle, Anna B. Austin, Stella E. Knouse, Florence A. Minnich, Clara Cammerer, Lillian Baer, Celia J. Harris, Mary E. Hupman, Lula P. Crew.

THE commencement of the University Hospital Training School for Nurses was held May 15 at Lehmann's Hall. Those who received diplomas were:

Misses Mattie Estelle Coale, Maryland; Agnes May Lynch, Florida; Marion Campbell Smith, Maryland; Alice Maud Wells, Canada; Lucy Lee Harvey, Maryland; Mary Juliette Miles, Maryland; Eulalia Murray Cox, West Virginia; Bernice Victoria Conner, Maryland; Lena Elizabeth Stouffer, Maryland; May Katherine Steiner, Maryland; Eliza Nalley Ridgely, Maryland; Ann Ethel Logue, Pennsylvania; Lilian Freeman Blake, Maryland; Blanche Louise Prince, Maryland; Ethel Mayotta Dawson, Maryland; Lucy Marian Lilly, Georgia.

At the graduation-day exercises of Johns Hopkins Hospital Training School for Nurses diplomas were granted to the following:

Misses Adelaide A. Abele, Zanesville, Ohio; Emma A. Adams, Vanceburg, Ky.; Grace Douglas Barclay, Baltimore; Mildred Hallowell Bentley, Sandy Spring, Md.; Alfreda Brown, Sparta, Ga.; Ellen Barker Cloud, Pembroke, Ky.; Claire Ridgely Craigen, Baltimore; Helen Hamilton Crowther, Knoxville, Tenn.; Beatrice Farnsworth, Lincoln, Mass.; Mary Flint, Toronto, Ont.; Josephine Morris Frazer, Russellville, Ky.; Hester Frederick, Baltimore; Kittie J. Gerber, Greensburg, Pa.; Jessie Marjory Groves, St. Catherine's, Canada; Bee Seymour Hoiles, Greenville, Ill.; Marie I. Hutchins, Baltimore; Ethel Louise Jones, Baltimore; Jeanette Williams Lord, Portland, Maine; Anna Eleanor McDonald, Washington, D. C.; Geraldine K. Martin, Toronto, Ont.; I. Alberta Meyers, Petersboro, Canada; Natalie Washburn Nixdorff, Hartford, Conn.; Katherine M. Olmstead, Des Moines, Iowa; Ada W. Pike, Toronto, Ont.; Nell Montimer Pottenger, Liberty, Ind.; Adelaide Maurey Reardon, Baltimore; Winifred E. Robinson, St. Thomas, Canada; Rosalind M. Shantz, Preston, Canada; Mary G. Smethurst, St. Augustine, Fla.; Harmina W. Stokes, Washington, D. C.; Irene Tabb, Martinsburg, W. Va.; Lucy A. Tooker, New Orleans, La.; V. Treutle, Rowlesburg, W. Va.; Helen Keene Troxel, Baltimore; Nellie Penman Wilkins, Tilsonburg, Canada; Elizabeth Nichols Wilson, Richmond, Va.; Daphne N. Yates, Fernandina, Fla.

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THE GASTRIC CRISES OF TABES.*

By Julius Friedenwald, M.D.,

Baltimore,

Professor of Gastroenterology.

and T. F. Leitz, M.D.,

Baltimore.

Associate in Gastroenterology, College of Physicians and Surgeons, Baltimore, Md.

GASTRIC crises are among the most important as well as the most interesting symptoms observed in locomotor ataxia. As early as 1842, Graves reported the results of his study of a case affected with this peculiar gastric disturbance occurring in the course of a nervous disorder. Romberg, in 1851, and Grube, in 1859, reported similar observations, without attracting attention to any relation existing between the gastric affection and tabes; while Trousseau cited a case of a female in whom the lightning pains preceded the gastric pains; he did not, however, establish any special connection between the gastric upset and the coincident tabetic disease. Charcot, in 1868, and 1872, described classically the gastric symptoms of tabes, and observed that, in addition to locomotor ataxia, other affections of the spinal cord may be accompanied by these symptoms. His work forms the basis of all that has since been established in the study of this affection.

In 1882, Leyden (1) described the crises occurring in the disturbances termed by him as "periodic vomiting," a condition not associated with any special lesion, and Sahli, in 1885, presented his observation on the gastric chemistry of tabes both in the crises and during the intervals, and concluded that the crises are due to a hyperchlorhydria. Rosenthal (2) and Somomi (3) confirmed Sahli's observations, while Boas (4) and Van Noorden (5) demonstrated exceptions to Sahli's views, and Huchard and Bovet (6) called attention to the possibility of variations in the gastric chemistry even during the crises. The last observations were con-

*Read at the annual meeting of the Medical and Chirurgical Faculty of Maryland, April 24, 1912.

firmed later by Babon (7) (1905), who established the fact now usually admitted that there is not any distinctive chemistry of the stomach secretion in the gastric crises of tabes.

In the usual forms of gastric crises the following characteristic symptoms are observed: Suddenly, and without warning, the condition is ushered in by paroxysms of pain in the abdomen, lasting a variable period of time, and ceasing abruptly; the digestive functions being entirely normal in the interval. The paroxysm may be accompanied by the vomiting of a certain amount of mucus and of food, and may continue without cause for many hours, and even days; prodromal symptoms are rarely noted. Vulpian, however, reports a case in which an eruption on the thigh manifested itself upon the approach of each crisis; at times a general weakness or malaise precedes the attack.

The gastric crises of locomotor ataxia are ordinarily observed in the preataxic stage of the disease, often as the first symptoms, and may remain so for a long period, often many months, and frequently lead to errors in diagnosis. Thus Debove (8) observed a patient operated on successively for appendicitis, cholelithiasis, and for a movable kidney, and who was finally discovered to have been affected with locomotor ataxia.

According to Fournier (9), in 211 cases of tabes the *crises gastriques* were noted 15 times as initial symptoms. According to Erb, 10 times in 400 cases, and according to our observations, 5 times in 42 cases.

SYMPTOMS.

The important symptoms associated with the gastric crises are pain, vomiting and the effect upon the general health. The pain first manifests itself in the epigastrium, and radiates throughout the abdomen, back and limbs. From the onset the pain is usually most violent; occasionally, however, it may be quite moderate and gradually increase in intensity to the greatest severity. With the pain there is often a marked cutaneous hyperaesthesia in the epigastric region, the slightest pressure eliciting at times the most agonizing pains; at other times pressure upon the abdomen is practiced by the patient to subdue the severe pain.

The pain may last for many hours, and at times many days; but usually is not continuous, and the paroxysms are of short duration, a period of relative calmness succeeding them. The vomiting takes its onset coincidentally with the pain, occurring quite as frequently before as after meals. The vomitus consists of a glairy mucus secretion containing at times some food, often tinged with bile, and occasionally with blood. As soon as the stomach has been emptied of its contents the effort at vomiting becomes more and more severe, and the straining adds to the severity of the pain. The vomiting may become incessant, and occasionally it becomes uncontrollable. Excessive quantities of secretion may be vomited at times, as much as from two to three litres.

Due to the extreme pain and excessive vomiting, the strength

of the patient is much reduced, and he becomes more weakened, while the intolerable vomiting, rendering feeding impossible, increases the depression. The patient becomes indifferent to his surroundings; his body becomes bathed in profuse perspiration; the extremities become cold; the pulse is small and rapid; the respirations are accelerated; there is extreme anorexia and intense thirst, and, according to Marie, this condition may be most aptly compared to a severe attack of sea sickness. Death due to gastric crises is exceedingly rare, though this has occurred as a result of collapse. Vulpian (10) reports a case of this kind.

On examination, the patient presents a retracted abdomen, which is painful to pressure. A succussion sound is usually absent; occasionally there are eructations and hiccough; abdominal distention is not frequent. Areas of cutaneous hyperesthesia over the abdomen are frequently observed; occasionally areas of anesthesia.

The analyses of the gastric secretion have been a matter of considerable interest in this affection. The most important observations are those of Babon (11), Sahli (12), Rosenthal (13), Simoni (14) and Robin (15), who found an increase in acidity, while Van Noorden (16) obtained very variable results in several observations. He concluded that the gastric juice varied as to the acidity very materially, even in the same individual in the same crisis or in different ones.

Huchard and Bovet (6) observed repeated variations in the chemistry of the stomach contents even in the same individual, and conclude that these variations are important as a factor in the diagnosis between the gastric crisis of tabes and ulcer of the stomach. Bubon (11) classifies 17 cases as follows:

Hyperacidity in.....	7
Hyperacidity with hypersecretion.....	1
Hypoacidity in.....	7
Anacidity.....	1
Crisis with variable conditions.....	1

In the interval the gastric secretion undergoes the same variations as during the crisis.

The intestine frequently participates in the disturbances, and with the gaseous distention there may be great expulsion of gas from the bowels. At times the intestinal disturbances are marked, and are accompanied by a continuous diarrhea, the stools containing mucus and bile; in consequence, the patient becomes exhausted and extremely ill. At times gastric crisis coexist with other crises, as intestinal, rectal, vesical, cardiopulmonary or laryngeal.

COURSE AND DURATION.

The gastric crises appear at longer or shorter intervals; these may be as long as six months or more; at times, a few months or only a few days. Appearing in the preataxic stage, they increase in severity as the malady advances, the periods of intermission

being shorter and the crises more prolonged; at times they become prolonged almost indefinitely and with but little remission.

Occasionally diminution in and a disappearance of the crises has been noted as soon as the motor symptoms become marked. The crisis itself varies greatly in duration. It terminates in 24 to 48 hours, or it may be prolonged for several weeks. Soupault (17) describes two forms—a short crisis, the duration of which is but one to two days, and a severe form, which is prolonged from eight to fifteen days or more, and which reacts severely on the patient's general health, and is followed by marked depression and exhaustion.

TERMINATION.

In milder forms, as soon as the pain and vomiting subside, the appetite quickly returns, and the patient partakes of a full meal and digests it well, but in the severe forms, even after the cessation of the vomiting and disappearance of pain, the return to health is gradual; in a certain number of cases the digestion becomes perfectly normal, while in others dyspepsia continues for a longer or shorter period of time. The gastric crises may exceptionally terminate fatally, due either to cardiac exhaustion or to exhaustion produced by profuse diarrhea.

CLINICAL FORMS.

Sainton and Tronc (18) describe six varieties of gastric crises:

I. *Mild Variety*: This form is very rare; it was first described by Fournier (9); it is accompanied by pain, but with little vomiting.

II. *Abortive Variety*: There are two varieties of this condition—(a) vomiting variety and (b) gastralgic variety.

In the vomiting variety there is an absence of pain and of general symptoms. The crisis is indicated by paroxysms of vomiting of food and mucus. This condition is accompanied by vertigo and exhaustion, and the patient had but slight pain.

In the gastralgic variety there is no vomiting, but here are paroxysms of epigastric pain, often radiating toward the back.

III. *Severe Variety*: This variety is accompanied by extreme pain, so marked that all other symptoms are overshadowed, or by an intensity of the general symptoms, that the patient collapses. This is the most severe form of the gastric crises, and may lead to coma and death.

IV. *Complicated Variety*: This variety may be of two forms—that accompanied by hematemesis and that with hypersecretion. The variety accompanied by hematemesis is exceedingly rare; cases have been described by Charcot (19), Vulpian (20), Simoni (14) and others. The blood which is vomited is usually large in quantity, may be red, but is usually partly digested and coffee-ground in appearance. In the variety accompanied by hypersecretion, the patient is affected with an intermittent hypersecretion of gastric juice. This condition occurs in those forms of gastric crises associated with hyperchlorhydria.

V. *Abnormal Variety*: This variety is unusual on account of its duration and repetition. The crises appear daily at times, but may be of short duration; at times they may prolong over days, weeks and months.

VI. *Variety Containing Those Forms Alternating or Associated with Other Symptoms*: In certain cases the gastric crisis may alternate with other manifestations; cases have been recorded in which the crises are interrupted, accompanied or followed by attacks of angina pectoris. Labbé and Sainton record the clinical history of a patient who passed through three phases—laryngeal crises, attacks of angina pectoris and gastric crises. In this variety the crises occurring in patients having dyspepsia are of importance; they do not cease abruptly, but are followed by periods of gastric distress, which disappear under careful treatment, but reappear with excesses in food or drink. In hysterical individuals affected with tabes, the gastric crises and hysterical crises are apt to be associated. The vomiting is exaggerated, and the symptoms of hysteria are apparent. It is possible, therefore, to have two forms of crises in the same individual—the usual form of gastric crises of tabes and the hyperopseudocrisis appearing in tabes. Of interest, too, are the gastric crises appearing in individuals addicted to the use of morphine. Mathieu (21) has called attention to this condition. It is not uncommon for patients affected with gastric crises of tabes to become addicted to the use of morphine. In such individuals the crises become more and more frequent, and at times almost continuous.

DIAGNOSIS.

When the symptoms of the gastric crises are pronounced, they are so well known that the diagnosis becomes a simple matter. When the diagnosis is not made under these conditions, it is usually due to the fact that the possibility of a tabetic condition is not borne in mind. The physician is frequently called upon to look into some apparent gastrointestinal disturbance, and the nervous phenomena are not taken into consideration. Frequently the signs of tabes are not sufficiently marked, and an error in diagnosis is therefore pardonable. At times the signs are not complete, and the diagnosis becomes difficult.

DIAGNOSIS BETWEEN HEPATIC COLIC AND GASTRIC CRISES.

In both conditions vomiting of bile is not infrequent; however, the pain located in the region of the gall-bladder, radiating to the back, renders the diagnosis of cholethiasis a simple matter; in addition, the bile-stained urine, the icterus, the enlargement of the gall-bladder add additional evidence to the diagnosis.

Nephritic colic may be confounded with gastric crises, but the constant location of the pain in the region of the kidney and the urinary changes point to the correct diagnosis. The difficulty in diagnosis, however, becomes greater in those rare forms of tabes

accompanied with nephritic crises such as have been described by Maurice Raynaud (22).

Dietl's crises can usually be distinguished from gastric crises by physical examination. The symptoms of lead colic frequently resemble the gastric crises of tabes. In lead colic vomiting is unusual; constipation is marked; retraction of the abdomen is present, and the blue line around the gum permits the diagnosis usually to be made without difficulty. Attacks of intermittent hypersecretion frequently resemble the gastric crises, but their onset is much less sudden, and on emptying the stomach large quantities of gastric secretion are obtained. The attacks of gastroxynsis of Rossbach in which migraine attacks observed in young individuals following intellectual pursuits, are accompanied by the vomiting of acid gastric secretion, sometimes resemble gastric crises; the attacks, however, usually take their onset after meals; the headaches are intense; severe eructations manifest themselves, followed by vomiting. After vomiting the patient is relieved, takes nourishment and is well the next day. Of the greatest importance is the fact that these attacks usually come on while the patient is pursuing his mental work, and disappear on holidays, and thus are easily distinguished from gastric crises.

Gastric crises of hysteria are much less violent than those of tabes. They are accompanied by the eructations of gas or the expulsion of flatus from the bowels, and with abdominal distension; vomiting is frequently present. These attacks occur in hysterical individuals when subjected to mental anxiety. Hysterical crisis frequently alternates with the gastric crisis of tabes, and, according to Vires (23), in hysterotabes each disease is so represented as if it were alone present.

In the gastric crisis of neurasthenia the attacks appear after fatigue. They are accompanied by headaches and disappear with thorough purging. The gastric crisis which appears in the course of other nervous diseases, such as in general paralyses, multiple sclerosis, etc., presents the same symptoms as that of tabes. A thorough examination of the nervous system will distinguish the crisis of tabes from that of other nervous affections. Under the caption of periodic vomiting, Leyden has described a peculiar train of symptoms in which patients present attacks much like those of gastric crisis, but other signs of tabes are never present.

PATHOGENESIS.

In the autopsies of patients who have succumbed to tabes and who have been affected with gastric crises, one rarely finds any lesion in the stomach. Crouzon (24) reports a case in which small hemorrhages with melena existed for 15 years, revealing at autopsy an atrophy of the stomach. In a case in which hematemesis was present, Mathieu (21) was unable to discover any ulceration in the stomach.

Two theories have been propounded to explain the nature of the gastric crises: First, that the condition is due to some derange-

ment of the nervous system; second, to a functional disturbance of the stomach.

NERVOUS THEORY.

According to Hayem (25), the gastric crisis of tabes is a form of gastric neurosis, while Bouveret (26) considers the condition neuralgic. Other writers have attempted to lay the cause to one or other of the nerve supplies of the stomach, the pneumogastric or the sympathetic. Buzzard (27) attributes this phenomena to the sclerosis of the pneumogastric, while Roux (28) considers the condition to be due to some disturbance of the sympathetic system.

GASTRIC THEORY.

Sahli (12), on the other hand, believes the gastric crises are due to some change in the chemistry of the stomach, and that the hyperchlorhydria present plays an important rôle in its production. The chemical theory of the production of the crises is untenable.

PROGNOSIS.

The prognosis of the gastric crises is grave. The intensity of the pain; the frequent vomiting greatly fatigue the patient and lead to rapid emaciation, loss of strength and anemia, and often tend to the contraction of the morphine habit.

TREATMENT.

The indication for treatment is to allay the severity of the crisis and to prevent if possible a return. In the treatment of the crisis itself, when the pain and vomiting have become excessive, abstinence from all food should be insisted on. At times liquid food may be given, as albumen water and ice-cold milk in small quantities. When special remedies can be retained, some relief may be given the patient. Among these remedies are oxalate of cerium, extract of cannabis indica, extract of belladonna, the bromides and chloroform. Among the sedatives, cocaine, codeine and morphine exert a favorable influence at times upon the crises. Remedies acting directly upon the stomach itself rarely yield results; when a hyperchlorhydria is present, the alkalies are indicated. For the relief of pain, the external application of sprays of ether or the local application of ice is useful. Some relief is at times obtained by means of a galvanic current of from 10 to 15 milli-amperes, the positive pole being applied to the spine, the negative to the abdomen. Occasionally the application of X-ray or radium gives relief. Lavage of the stomach is rarely of benefit, except in those patients suffering with a coincident dyspepsia.

Gastric crises have been subdued in two cases by Debove (29) by simple lumbar puncture. Similar results have been obtained by Babinski (30) by the same method. Unfortunately, none of the methods of treatment cited can be relied upon, and the patient is often forced to obtain relief by means of hypodermic injections of morphine, which must be used with great caution, inasmuch as the morphine habit is apt to be contracted.

When the crises have become unbearable, the operation of rhizotomy, as recommended by Foerster, should be performed; this consists in the resection of the posterior spinal nerve roots. The object is to resect the sensory gastrointestinal fibers of the sympathetic nerve, and this may require resection of the roots from the twelfth to the fifth dorsal, or even higher. Between attacks it is important to apply treatment and so attempt as far as possible to avoid the onset of the crises. Stimulants should be avoided. Roux and Achard insist on the benefit obtained from the use of milk and buttermilk. Nitrite of sodium has been recommended by Raymond and found effectual when administered in increasing doses.

In all cases of tabes with gastric crises Wassermann reactions should be made not only of the blood, but also of the spinal fluid. Whenever the reaction is positive, the most active antisypilitic treatment should be instituted. The most beneficial results are at times obtained in this condition from this form of treatment.

PERSONAL EXPERIENCE.

Our observations extend over a series of 42 cases of tabes in which attacks of gastric crises occurred. The patients were all males, whose ages ranged from 29 to 64 years. The attacks of gastric crises were noted five times as an initial symptom of the tabetic disease. Severe pain was noted in 11 cases, was moderate in 9 cases and variable sometimes, severe and sometimes moderate in 22 instances. Severe attacks of vomiting were observed in 23 instances; moderate in 12 and variable at times, severe and again moderate in 7 cases. The general health of the patient was affected as a result of the crises in 25 instances in our series; the general health was not affected in 17. The gastric secretion was examined both during the crises and in the interval. The secretion was obtained during the crises of 35 patients; it contained a normal amount of acid in 6 cases, while hyperchlorhydria existed in 13, hypochlorhydria in 10, and the gastric secretion was variable in its acidity in 6. The gastric secretion was secured during the interval of the attacks in 36 cases. There was a normal acidity in 14 instances, hyperchlorhydria in 12 and hypochlorhydria in 10.

If we classify our 42 cases according to the plan of Sainton and Tronc, 6 cases would fall in the mild variety—that form accompanied by pain, but with little vomiting. Of the absorptive variety, there were 9 cases of the vomiting form and 5 of the gastralgic. Of the severe variety, we note 3; this is the form accompanied by extreme pain and collapse. In the complicated variety there was 1 with hematemesis and 4 with hypersecretion. In the abnormal variety, that form with very frequent repetition of attacks, there are 3 cases, and in the variety alternating or associated with the other symptoms, 11.

Table Illustrating the Various Conditions Associated with the Forty-two Cases of *Tabes with Gastric Crises*.

No. of cases.	Age.	Gastric crises as initial sign of disease.	Pain.	Vomiting.	Effect on general health.	Gastric secretion	
						During crises.	Between crises.
1	60	No	Severe	Severe	Severe	Hypochlorhydria	Normal
2	34	Yes	Variable	Variable	Severe	Hypochlorhydria	Hypochlorhydria
3	58	No	Severe	Severe	Severe	Hypochlorhydria	Normal
4	42	No	Variable	Moderate	Slight	Normal	Hypochlorhydria
5	59	No	Moderate	Severe	Severe	Hypochlorhydria	Hypochlorhydria
6	61	No	Severe	Severe	Severe	.....	Normal
7	53	No	Variable	Moderate	Slight	Hypochlorhydria	Hypochlorhydria
8	33	No	Severe	Severe	Severe	Hypochlorhydria	Hypochlorhydria
9	46	No	Variable	Moderate	Slight	Hypochlorhydria	Hypochlorhydria
10	53	No	Variable	Moderate	Slight	Hypochlorhydria	Normal
11	35	No	Moderate	Severe	Slight	Normal	.....
12	29	No	Variable	Severe	Severe	Hypochlorhydria	Hypochlorhydria
13	44	Yes	Moderate	Severe	Slight	Normal	.....
14	39	No	Moderate	Severe	Slight	Hypochlorhydria	Hypochlorhydria
15	46	No	Moderate	Severe	Slight	Hypochlorhydria	Normal
16	42	No	Variable	Severe	Severe	Hypochlorhydria	Hypochlorhydria
17	37	No	Variable	Severe	Severe	Variable	.....
18	55	No	Severe	Severe	Severe	Normal	Normal
19	48	No	Moderate	Severe	Severe	Hypochlorhydria	Hypochlorhydria
20	32	Yes	Severe	Moderate	Slight	.....	.....
21	57	No	Variable	Severe	Severe	Variable	.....
22	64	No	Severe	Severe	Severe	Normal	.....
23	62	No	Variable	Severe	Severe	Hypochlorhydria	Hypochlorhydria
24	59	No	Variable	Severe	Slight	Hypochlorhydria	Hypochlorhydria
25	62	No	Variable	Moderate	Severe	.....	Hypochlorhydria
26	44	Yes	Moderate	Severe	Slight	Hypochlorhydria	Hypochlorhydria
27	54	No	Variable	Moderate	Severe	Normal	Normal
28	30	No	Severe	Severe	Slight	.....	Hypochlorhydria
29	41	No	Variable	Moderate	Slight	Hypochlorhydria	Hypochlorhydria
30	55	No	Moderate	Variable	Slight	Variable	Normal
31	51	No	Moderate	Severe	Severe	Hypochlorhydria	.....
32	23	No	Variable	Severe	Severe	Hypochlorhydria	Hypochlorhydria
33	41	No	Severe	Severe	Severe	.....	Hypochlorhydria
34	59	No	Variable	Moderate	Severe	Hypochlorhydria	.....
35	56	No	Variable	Variable	Slight	Normal	.....
36	52	No	Moderate	Severe	Slight	Variable	Hypochlorhydria
37	47	No	Severe	Moderate	Slight	Hypochlorhydria	Normal
38	41	No	Variable	Severe	Slight	.....	.....
39	49	Yes	Variable	Moderate	Slight	Hypochlorhydria	.....
40	58	No	Severe	Variable	Slight	Hypochlorhydria	Normal
41	61	No	Variable	Moderate	Slight	Variable	Normal
42	46	No	Variable	Severe	Severe	Hypochlorhydria	Hypochlorhydria

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¹For a full description as well as bibliography of this subject the reader is referred to the very complete paper of Salnton and Tronc, *Gazette des hôpitaux*, 183 and 219, 1908, to which the writers are greatly indebted for much of the information contained in this article.

NERVOUS AND MENTAL DISEASES. By Archibald Church, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence in the Northwestern University Medical School (The Chicago Medical College), Chicago; Late Professor of Neurology in the Chicago Polyclinic; Neurologist to St. Luke's, Wesley, and Mercy Hospitals; Consulting Neurologist for the Michael Reese Hospital, the Home for Destitute Crippled Children, etc.; and Frederick Peterson, M.D., Ex-President of the New York State Commission in Lunacy; Professor of Psychiatry, Columbia University; Consulting Alienist, Bellevue Hospital; Manager for the Craig Colony of Epileptics, at Sonyea, New York; Ex-President of the New York Neurological Society. 343 illustrations. Seventh edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1911. Cloth, \$5.00 net; Half Morocco, \$6.50 net.

The present edition of Church and Peterson is of the same high degree of efficiency as its predecessors. It is an ideal treatise on nervous and mental affections, covering the field thoroughly and concisely. While the subjects included are fully treated, still too much space is not devoted to any one to make the book too cumbersome or unwieldy for student or general practitioner use. The book is modern in every sense and should be as popular with the medical profession as the preceding issues.

WHAT IS MARYLAND DOING IN HER FIGHT AGAINST TUBERCULOSIS?

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IN outlining what Maryland is doing to prevent and cure tuberculosis I shall enumerate the various agencies which have proved of use in the warfare against this disease, try to point out the especial value of each respective agent, and then show to what extent Maryland is now using these methods.

The varied conditions of economic and social life necessitate an attack against tuberculosis which must be directed, not from only one standpoint, but from several. Each method of attack or of prevention must be based on the best possible means to accomplish the end against opposing factors occurring in the social life and also arising by reason of insufficient financial wealth on the part of the individual. Consequently, today there are in active operation all over the country—

1. Sanatoriums.
2. Dispensaries.
3. Visiting nurses and physicians.
4. Day camps.
5. Night camps.
6. Farm colonies.
7. Outdoor schools.
8. Hospitals and infirmaries for advanced cases.
9. Board of health and police regulations.
10. Associations for the study and prevention of tuberculosis.

The sanatorium is of value because it affords a place for treatment under the best hygienic conditions and under constant supervision. It is of value principally to the incipient and but moderately advanced cases, and is essentially used to cure or restore to working capacity within a limited period. In a sanatorium the benefits of treatment show themselves sooner than under ordinary conditions, and the tendencies to relapse are more carefully guarded against. But more important, perhaps, is the educational factor. The patient is brought daily face to face with the efforts exerted in his behalf and for his recovery, he sees the results upon himself and upon others, almost unconsciously he learns the principal factors in treatment, and when he leaves he is more or less an apostle

of the principles of hygienic living. He spreads the doctrine of sputum destruction and infectiousness. The limited stay of a patient, however, is a disadvantage to the sanatorium. The long protracted course of the disease makes it necessary that the patient must be longer advised, watched and warned. The sanatorium may be likened to an university or college where, after having taken his degree, the patient goes out into the world to fight his battles himself, aided or unaided, as the case may be, by other agencies.

The dispensary serves a twofold purpose. The first prevention, the other treatment. All individuals are not so financially blessed as to be able to take their ills to a family physician. The dispensary is their recourse. Here they come for diagnosis of their complaints and for advice and treatment. In this way many early cases of tuberculosis are seen and sent to suitable institutions or advised how best to treat themselves and prevent their infecting some other individual. In like manner the far advanced case is taken care of. At stated intervals those who are physically able report on their conditions and are given treatment and advised what it would be best for them to do. The discharged sanatorium patient may go here to report how he is getting along and to get further advice and treatment. Further, the discovery of a case of tuberculosis in a family gives a clue where to find more and perhaps better cases. And here is where part of the work of the visiting physicians and nurses is directed.

The tuberculosis or district nurse goes into the homes of those afflicted with tuberculosis and thereby reaches the very foundation upon which the variety of treatment must be based. To the unfortunate patient and to his family she tells the principles of hygiene, explaining why and wherefore they are of benefit to the individual and family. The material needs are seen and the family is instructed where and how to apply for aid. When poverty is all too evident the nurse endeavors to persuade the patient to enter an institution for his care. Besides all this, she is called upon to do actual nursing to the helpless patient. All together the work of the visiting nurse is one of almost uncertain value. By reason of mental and other deficiencies on the part of the families the nurse may visit, the success of her operations is oftentimes nil, but the proportion of success warrants her work until at least a more successful means is employed.

The day camp is especially useful for that type of cases which for one reason or another is unsuitable for the incipient sanatorium, and, moreover, is not so far advanced as to require treatment in a hospital for advanced cases or at home. It is a convalescing home for the intermediate case. For parts of each day the patient may

come here and pursue the treatment out in the open air and under good hygienic conditions, and at a very limited expense.

The night camp is essentially for those who are able to keep up their work, providing they have somewhere to sleep in the open air and under good conditions. Here they sleep well sheltered, and may procure the two necessary meals—supper and breakfast—at a very low cost. In this way many a working life is prolonged.

Some patients after discharge from the sanatorium or after partial treatment are not physically able to go back to work in the city without grave chances of a breakdown. A farm colony or place in the open country air where such patients may be given light employment for a few hours daily and in the meantime build up their strength and make more permanent their recovery is a very beneficial institution in prolonging life and usefulness.

The open air school for the tuberculous child allows treatment and education to go on hand in hand and at the same time reduces the chances of infection for the healthy by reason of the segregation. Preventorium for the child inclined for physical reasons to tuberculosis do much to build up health and fight the disease.

But probably the most important of all, from the standpoint of infection, is the hospital for far advanced and destitute cases. The patient who is no longer physically able to support himself or minister to his needs and those who will not carry out the preventive measures are taken care of here. The danger of infection from the helpless or careless far advanced case is, in this way, greatly lessened. One big factor in the propagation of the disease is thus nicely taken care of.

The board of health, backed by police power and regulation, reduces the dangers of infection by enforcing the laws relating to promiscuous expectoration, nuisances and infringements on the public hygiene. By making compulsory notifications of all infectious diseases it points out the source of danger, so that it may be properly dealt with.

The associations study the means and methods of attack. They educate the public through exhibitions, lectures, literature, etc. They bring about proper legislation and in a general way act as the central directing force.

In what respect and to what degree has Maryland employed these curative and preventive measures?

The beginning of the official fight against tuberculosis in Maryland took place when Dr. Fulton, who was at that time secretary to the State Board of Health, addressed to Governor John Walter Smith on November 5, 1901, a communication containing an appeal for active legislation and a campaign against tuberculosis such as was being waged by other States at the time. Accordingly in 1902, at the Governor's suggestion and by official act of the General

Assembly, the original tuberculosis commission was appointed by the Governor. The men who served on this committee did so without recompense and did valuable and conscientious service. The commission of six was as follows: Dr. Wm. S. Thayer, president; Mr. John M. Glenn, secretary; Drs. W. Frank Hines, Lillian Welsch, Marshall Price and Mr. George Stewart Brown.

In his message to the Assembly in January, 1904, Governor Smith spoke, in part, as follows: "The loss in the productive capacity of the State by reason of the great number of people incapacitated by tuberculosis, and those whose time must be given to nursing the sick, must be enormously greater than the cost of caring for the sick in scientifically-arranged institutions, in adopting simple precautionary measures."

At this time it was estimated that fully 10,000 cases of tuberculosis existed in the State, and that over 2000 died thereof per year. But the work of the commission was of conclusive nature, and consequently by an act of the Assembly of 1906, \$100,000 was appropriated for the Maryland State Sanatorium. Prior to the appointment of this commission there were in existence in the State three tuberculosis hospitals and sanatoriums. Since 1902 interest has so awakened that in the State there are now six hospitals and sanatoriums, five organized tuberculosis dispensaries and nine anti-tuberculosis associations. A gain in nine years of three hospitals and all the dispensaries and associations. Those institutions which were in existence prior to 1902 and the original tuberculosis commission were:

1. The Municipal Hospital at Bayview, which now accommodates 165 patients and receives all classes of cases amongst the destitute of Baltimore. This hospital may be spoken of as the institution for far advanced cases for the city of Baltimore.

2. The Hospital for the Relief of Crippled and Deformed Children of Baltimore, located on North Charles street and in the Baltimore suburbs (by Mr. Kernan's gift), and which now has provisions for 50 child patients with non-pulmonary tuberculosis.

3. The Hospital for Consumptives of Maryland, or Eudowood Sanatorium at Towson. This institution was opened in 1896. It receives all classes of cases, and has beds for 112 patients. Of these, 50 beds are for incipient, 34 for far advanced, 13 for a farm colony, and 15 for ex-patients who are employes.

Since 1905 there have been opened three sanatoriums:

1. The Starmont Sanatorium at Washington Grove, opened in 1905. It has a capacity of 35 beds, and is essentially a private institution.

2. The Jewish Home for Consumptives of Baltimore, located at Reisterstown, was opened in 1908, and has a capacity of 46 beds. It receives all classes of cases, and is free.

3. Finally, the Maryland State Sanatorium for Tuberculosis was opened in 1908. It has accommodations for 210 patients, and admits all classes deemed curable or likely to make steady improvement.

This sanatorium is situated at a place called State Sanatorium, near Sabillasville, and on the main line of the Western Maryland Railroad, 69 miles northwest of Baltimore, and in the extreme northwest of Frederick county. Elevation 1450 feet. The State grounds consist of 198 acres of land, which, with buildings and improvements, represents an outlay of approximately \$265,000. For the patients there are nine separate buildings on the shack principle, each accommodating 20 patients, an infirmary for 20 more and a cottage for 10 convalescents and arrested cases.

There is a central dining-room in the administration building, to which all patients, except those in bed, must go for their meals. All patients are at first put at rest and watched. Later walking is instituted if the patient's condition permits, and after this has been done for a while the patient is given first light work to do, and next various amounts and character of the work which is necessary for the proper maintenance of the institution. Finally, when able, he is allowed to work for his keep.

Of course, the location of the shacks makes the accommodation of bed patients a limited one. Under a recent appropriation a new unit of administration is being constructed to accommodate 200 more patients. Here everything will be so compact that a big majority of these patients can well be taken care of as bed cases. Thus the capacity of the State Sanatorium will be 410 beds, which better provides for the need of the State, but which is not sufficient.

So much for the sanatoriums. The dispensaries, with one exception at Frederick, are all located in Baltimore. The Phipps Dispensary of the Johns Hopkins Hospital was opened in March, 1905. The department of diseases of the lungs of the University of Maryland Dispensary was established in 1906, while in February of the same year the tuberculosis clinic of St. Luke's Hospital was first begun. In 1907 the Christ Church Tuberculosis Dispensary was opened by the Maryland Association for the Prevention and Relief of Tuberculosis. Baltimore city is benefited much by these institutions, but their number is insufficient.

The Maryland State Association for the Prevention and Relief of Tuberculosis was founded in December, 1904, and has established branches in the following places:

1. Annapolis, Anne Arundel county, established 1906.
2. Cambridge, Dorchester county, established 1906.
3. Frederick, Frederick county, established 1907.
4. Cumberland, Allegany county, established 1909.

Besides these State associations, there are :

1. At Easton—Sanitation Committee-Civic League of Talbot County, 1908.
2. At Rockville—Social Service League of Montgomery County, 1908.
3. At Snow Hill—Association for the Prevention and Relief of Tuberculosis, 1909.
4. Hagerstown Civic League, 1911.

It may be of interest to add here that though the association was not founded until December, 1904, Maryland was the first clearly to demonstrate, in January, 1904, the usefulness of one of the functions of an association. I speak of the public tuberculosis exhibition held in McCoy Hall of the Johns Hopkins University during the week beginning January 25, 1904. This was the first exhibition of its kind attempted in America, and its value has been so clearly established that throughout the land exhibits are constantly being planned and carried on. It may also be said that in formally opening the exposition Governor Edwin Warfield made his first official appearance in public. Dr. Wm. S. Thayer, the president of the tuberculosis commission, at the opening of the exhibition, in explaining its purpose, said as follows: "Today we all realize and appreciate that if we knew how a terrible pestilence arises, and, more than this, how it may be prevented, we have gained a new duty; we must each one of us do his utmost to prevent it. But we know also that individual effort—the single deed, the private sacrifice—however unselfish and earnest and courageous, will be of little avail. It is only by combined and enlightened and continued labor that we can accomplish our ends. * * * We know all of these things about tuberculosis, and that is why we are here this evening to take counsel together, to put shoulder to shoulder in the furthering of a great and noble work."

Of the visiting nurses, Baltimore city has at present 15, with provisions for increasing this entirely inadequate number. Frederick has two, Cumberland one, Rockville one, and Hagerstown is about to have one.

The Board of Health regulations of the State are amongst the best in this country. Principally among these we might mention: 1. The compulsory registration and reporting of all cases of tuberculosis, the provisions of which you all know. 2. The prohibition of promiscuous expectorating in public places and on sidewalks. 3. The prohibition against the importation of infected cattle into the State.

Thus we see that Maryland, with a population not much over 1,000,000 people, has provisions in sanatoriums for over 500 patients, and soon will have accommodations for over 700 patients.

The State is doing well in this respect, but has it done what it should?

What has the State done for the colored race, to whom much of the present mortality rate from tuberculosis is due? These people are sources of infection, and as the infective agent doesn't discriminate as to color, the rest of the population also becomes the victim of careless and uncared-for tuberculous negroes. The two races cannot be cared for in the same sanatorium, although other agencies may be employed for both. There should be segregation of some kind in this State for the unfortunate victims of tuberculosis amongst the colored race.

There ought to be dispensaries in at least the principal cities of the State, and not confined to Baltimore alone. There ought to be hospitals for far advanced cases in every county of the State. These ought to be within easy reach of the majority of citizens, so that the advanced case would willingly stay, knowing that his people could afford to visit him.

Maryland established the first farm colony in this country, that at Eudowood Sanatorium. Why not expand along these lines and establish more? Their usefulness is clearly established.

Baltimore, Frederick, Cumberland, Rockville and Hagerstown have visiting nurses, whereas each community of 10,000 or more inhabitants should have at least one in connection with its dispensary.

There are no day or night camps, and it seems to me Baltimore or any of the larger cities of the State would profit in their establishment.

The absence of open air schools except the one at State Sanatorium or segregation of the tuberculous school child is a serious thing, and should require immediate and thorough attention, for at no age do individuals come in such intimate contact with one another as in their school days.

There should be an anti-tuberculosis association for at least each county, having headquarters at the county-seat. Also there should be proper accommodations for the tuberculous in penal institutions.

It has been estimated that the economic loss to the State from pulmonary tuberculosis is several millions of dollars per year. To combat this loss, approximately \$500,000 is spent. Is it good business?

Maryland has done much toward fighting tuberculosis. The results are showing themselves as time goes by. But it is not yet time to lay down arms. On the other hand, the battle should be waged even more strenuously and with greater equipment. We ought and must wipe out tuberculosis, if from nothing but the standpoint of economy. This industrial, financial loss must be done away with. Every uncared-for case of tuberculosis increases the chances of yourself or members of your family becoming victims. Will you do your share of the work in this great anti-tuberculosis fight?

Book Reviews.

A MANUAL OF CLINICAL CHEMISTRY, MICROSCOPY AND BACTERIOLOGY. By Dr. M. Klopstock and Dr. A. Kowarsky, of Berlin. In their "Institut für medizinische Diagnostik," in Berlin. Only authorized translation from the last German edition, thoroughly revised and enlarged. Illustrated with 43 textual figures and sixteen colored plates. New York: Rebusan Company., 1912. Cloth, \$3.00 net.

This book will be found uniformly adapted to students and practitioners. The text throughout is thoroughly reliable and can without hesitancy be recommended to prospective purchasers. Though designated a manual, it is in fact a small textbook, and contains quite exhaustive treatises on the bacteriological examination of the secretions and deposits in the mouth and pharynx, with directions as to the collection of the material to be examined, bacterial examination of nasal secretions, of conjunctival secretions, examination of sputum, feces, gastric contents, urine, blood, urethral and prostatic secretions, of fluids obtained by puncture, bacteriological examination of diseases of the skin, formulae of stains and culture media, etc. The thoroughness with which the subject has been covered should command the approbation of the student.

A CYCLOPEDIA OF AMERICAN MEDICAL BIOGRAPHY. Comprising the lives of eminent deceased physicians and surgeons. From 1610 to 1910. By Howard A. Kelly, M.D., Professor of Gynecologic Surgery at the Johns Hopkins University, Baltimore. Two octavo volumes, averaging 525 pages each, with portraits. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. 1912. Per set: Cloth, \$10.00 net. Half Morocco, \$13.00 net.

Dr. Kelly made the "ten strike" of his life when he published the present volumes. There is not a bit of doubt about the work he has done in his specialty, that it has been of a pioneer character, but sooner or later it will pass into oblivion. With the present volumes, however, as long as English is read "A Cyclopedia of American Medical Biography" will be sought as an authority for the period covered by it. It is to be hoped that this work will impress upon physicians the paucity of their information of their predecessors. It is the tendency of the times to think that everything good in medicine is a latter day innovation. It is true that

much in medicine and surgery have been introduced within the memory of some of those living. But it should be realized that these advancements would not have been possible without the work of those who have gone before. The physicians of America have added a great deal to the sum total of medical knowledge, which discoveries as a matter of national and professional pride should be instilled into the medical student. Although here and there is noted a minor typographical error, such as line 15, from bottom, second column, which should evidently read 1801, instead of 1901, one is impressed with the evident reliability of the biographical sketches of the 1200 deceased medical worthies of the United States and Canada. In fact they are on the whole much more reliable than such sketches in other books of like character. The editor has exhibited great judgment in the selection of those sufficiently distinguished to be included in a work of this character, and the reviewer realizes that some men of eminence had to be left out in order to bring the books within reasonable bounds. Certainly the character of their work should have admitted Doctors Francis T. Miles, J. Edwin Michael and Richard McSherry. However, Maryland has no cause for complaint as some fifty of her sons were considered sufficiently worthy to be allotted space. Besides the biographies there are a series of short sketches on Anatomy, Surgery, Bone and Joint Surgery, The Principles of Surgery, History of Gynecology in America, History of Obstetrics, Dermatology, etc. There is not a particle of doubt that this is the most important contribution to American medical history, and is the crowning glory of a life spent in the advancement of American medicine.

PELLAGRA. *An American Problem.* By George M. Niles, M.D., Professor of Gastro-Enterostology and Therapeutics, Atlanta School of Medicine; Gastro-Enterologist to the Tabernacle Infirmary, Atlanta Hospital and Atlanta Anti-tuberculosis Association; Attending Physician to the Tabernacle Infirmary Annex (for Pellagra), Atlanta, Ga. Octavo of 253 pages. Illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth. \$3 net. 1912.

Pellagra has become such a live issue in the United States that any communication on the subject cannot help but be of interest to the entire profession. At one time the supposition was that the affection was limited entirely to the South, but this contention has been proven erroneous. Now it is thoroughly recognized that undoubted cases of pellagra have occurred in every section of the Union. Such being the case, it is well for the pro-

fession as a whole to be awake to its possible occurrence, and to be able to recognize it when it does occur. The book is very opportune, and should be especially welcome to the physicians of Maryland, as pellagra has arisen in our State in individuals who have apparently never been outside of its confines; indeed, the reviewer knows of one case, which occurred in Kent Island, the patient never having been outside of Maryland, and to his knowledge having never been off the island. Pellagra, then, being so prevalent in the United States and so widely distributed, Americans should not leave its investigation to foreigners, but should seek its cause and cure.

The present work goes into the history of the disease, occurrence in the United States, etiology, symptomatology, pathology, diagnosis and treatment.

It is the etiology which chiefly concerns the medical man, for it is well-nigh impossible to treat the malady intelligently without knowing its causation. According to the writer, nothing definite has as yet been determined, but, in his opinion, so far the weight of evidence points to spoiled corn as the etiologic factor. He adduces some real good facts to substantiate the Zeistic theory, but as a conservative writer has fully set forth the other theories, and leaves it to the reader to settle the question to his own satisfaction.

Nothing new has been given as regards the treatment. The writer states that no specific treatment has been formulated. He strongly urges those who are financially able to sojourn during the hot months in a cold climate. This book has brought together into compact form our present knowledge of pellagra. It is written in good style, is conservative in its statements and is a distinct addition to pellagrous literature.

IMMUNITY. METHODS OF DIAGNOSIS AND THERAPY AND THEIR PRACTICAL APPLICATION. By Dr. Julius Citron, Assistant at the University Clinic of Berlin, II Medical Division. Translated from the German and edited by A. L. Garbat, M.D., Assistant Pathologist, German Hospital, New York. Twenty-Seven Illustrations. Two Colored Plates and Eight Charts. Philadelphia: P. Blakiston's Son & Co. Cloth, \$3 net. 1912.

Immunity has today passed from the theoretical to the practical stage; therefore, any material bearing on the subject from such a well-known authority as Dr. Citron is bound to attract notice. The present work takes up immunity from every aspect. The necessity of control tests, laboratory equipment, active immunity, tuberculin diagnosis, tuberculin therapy, toxin and antitoxin, agglutination, precipitins, bacteriolysins and hemolysins, method of com-

plement fixation, phagocytosis, opsonins and passive immunity are most comprehensively and entertainingly treated. The progressive physician should be acquainted with this aspect of medical progress, and the present work sets it forth in succinct, terse, plain form.

THE TREATMENT OF SHORT-SIGHT. By Prof. Dr. J. Hirschberg, Geh. Med. Rat in Berlin. Translated by G. Lindsay Johnson, M.D., F.R.C.S. With twelve illustrations. Cloth, \$1.25 net. New York: Rebman Company. 1912.

Hirschberg's monograph of a little over a hundred pages is the most complete exposition on myopia that it has been our pleasure to see in many days. In fact it is ahead of the times, though such a thing would seem impossible in such a subject as it treats. If general practitioners who are accustomed to fit glasses for this condition, we might even include oculists also, would read this book, they would awaken to the realization that there are many pitfalls of which they have been entirely unaware. Every page is filled with good advice and is a testimony to the long and careful thought bestowed by the author in his chosen field. A careful digestion of the book we are sure will impress upon the reader the importance of a proper conception of, and make him more careful and painstaking in fitting glasses for myopia.

THE SURGICAL CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO. April, 1912. Volume I. Number 2. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Published bi-monthly. Price per year: Paper, \$8.00. Cloth, \$12.00. Octavo of 291 pages, illustrated.

This, the second appearance of Murphy's Surgical Clinics, is both up to the form and excellence of its predecessor. In this volume the author has included such subjects as Ununited Fracture of the Tibia (Transplantation of Bone), Charcot's Ankle Joint, Ununited Fracture of Neck of the Femur, Arthritis of the Knee Joint, United Fracture of the Humerus, Ankylosis of the Knee (Arthroplasty), Ankylosis of the Hip (Arthroplasty), Cyst in the Left Iliac Fossa, Anastomosis of the External Popliteal Nerve. These are all burning questions and the possessor of this volume is indeed fortunate if he has one of these cases on hand. For here he can find at a moment the last word on bone surgery from the foremost exponent on bone work in the world. Dr. Murphy has greatly improved the technic of this branch of surgical art, and his latest conclusions are faithfully recorded in the present volume of his Clinics.

A TEXTBOOK OF OPHTHALMOLOGY. In the form of clinical lectures. By Paul Roemer, Professor of Ophthalmology at Greifswald. Translated by Dr. Matthias Lanckton Foster, member of the American Ophthalmological Society; member of the American Academy of Ophthalmology and Otolaryngology. With 186 illustrations in the text and thirteen colored plates. Volume I. 1912. New York: Rebman Company. Cloth, \$2.50 net.

Volume I contains chapters of Introduction on the Methods of Examining the Anterior Segment of the Eye, Diseases of the Conjunctiva and Cornea, Diseases of the Iris, Diseases of the Lens, and consists of 275 pages. If the preliminary volume is an index as to what is to come, the author and translator and publisher are one and all to be congratulated upon their product. It should not only appeal to the general practitioner, but should be welcome to the teacher, and especially to the teacher of ophthalmology, for its arrangement is ideal, the illustrations artistic and true to nature, and typography well executed. Especial emphasis is laid upon differential diagnosis, a subject sadly neglected by most writers. Generous space is allotted to mooted points on anatomy, physiology, etiology, treatment, etc., a welcome feature to teachers especially. But after all it is the diagnosis and treatment which especially concerns the general practitioner, and it is here that Roemer's book is surpassed by none and equaled by few, as the author possesses the happy faculty of saying what he has to say in trite, clear language. It is a masterpiece in clinical instruction, a method which has only lately come to be appreciated, and should be in the library of every practitioner of medicine, specialist and general practitioner alike.

CASES ILLUSTRATING RATIONAL TREATMENT OF HYSTERIA WITHOUT MINUTE PSYCHO- ANALYSIS.

By Tom A. Williams, M.B., C.M. (Edin.), Washington, D. C.

HYSTERIA is defined from its genesis; that is, by suggestion. Ten cases are described. They are divided into three types:

A. Where the causative suggestion is found to originate in some organic disease. This is the commonest type and the most practically important, because the hysteria often creates far more functional disability than does the disease which suggests it.

B. Cases in which the causative suggestion was not discovered because of insufficient psycho-analysis, but in which the secondary effects of the undiscovered suggestion which had become a habit were removed by psychomotor discipline, and the tendency to further hurtful suggestion was minimized by psycho-therapeutic measures, consisting of the readjustment of the patient's point of view. These cases are not uncommon in practice, are rarely cured either by mediate or immediate suggestion, and require a

knowledge of psycho-therapeutic technique for their successful treatment.

C. Cases of hysterizability, whether innate, from family predisposition or acquired, usually in childhood, on account of improper upbringing and lack of education in self-control, and against impulsivity and attention.

These cases are in want of pedagogical as well as medical assistance, but as those who usually come to the doctor do so because their ailment is supposed to be physical, the physician must become pedagogue toward these patients, at least until the false ideas as to their physical states, which have arisen from suggestion, have been transformed.

CASE I.—The first example complicated a hematomyelia of two years' standing, but a single interview enabled the man, a machinist, to go to work in spite of the organic defects.

CASE II.—Illustrates the failure of suggestive treatment to prevent relapses in a case of hysterical neuralgia.

CASE III.—The hysterical complication required separation from the results of an osteomyelitis, the effects of an injury and the dreamlike state produced by chronic alcoholism. This leads to successful therapeusis.

CASE IV.—Hysterical appendicitis of three months, cured by her own doctor in two hours.

CASE V.—Coccygodynia cured by her own doctor in four months after failure of numerous surgical operations.

CASE VI.—A habit spasm of an ilio-psoas originating in a chronic appendicitis, cured by 10 days' psychomotor discipline subsequent to an operation which had not improved it.

CASE VII.—Intense hyperesthesia of the patellar region, cured in a week by psychomotor discipline after several months' failure of powerful suggestions of various doctors.

CASE VIII.—Hysterical tic, cured in two interviews by psychomotor discipline.

CASE IX.—An aggravation of hysterical hypochondriasis of long standing, removed in a few weeks by rational persuasion.

CASE X.—Phobia in a boy of eight, cured by discipline guided by the date of a rapid psycho-analysis.

In treatment are discarded mystical impression, suggestive and emotional appeal, which are the main reliance of illicit practitioners and too many doctors, so that, as hysteria is the product of an idea, enlightenment by rational persuasion, combined with motor, sensory and psychic re-education, is the method used to reconstruct the patient's attitude. The therapist must think in terms of dynamo-genesis and avoid arbitrary empiricisms.

Finally, clear diagnosis of the mechanism to be overcome is essential, for the physician must not only aim at his object—normality—but must envisage each step of the process required. Nowhere is greater refinement essential.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor*

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BALTIMORE, JULY, 1912

CONSERVATION OF HUMAN LIFE.

Laws have been enacted for the preservation of our natural resources, so that now the physical assets of the country are fairly well protected against unnecessary depletion. This advanced legislation deserves the unstinted commendation of the American people. In the wild haste to protect the forests, the minerals, the water sources, etc., those who have been most active in the conservation propaganda have entirely overlooked the nation's most vital asset—human life. It has not apparently occurred to the employer that the best effort can only be gotten out of the physically fit. Even the Government has been derelict in its duty to the laboring class, allowing the employer unlimited sway in regards to the hours of employment, sanitary conditions surrounding the workshops, minimum age at which a worker would be taken on, etc. Gradually a national conscience has been awakened to the rights of the less fortunate. It is the duty of a good and beneficent Government to look out for and protect the ignorant from unscrupulous exploiters, and to so lessen the rigors of life that the offspring of the masses may at least get a fair chance to rise from the most abject depths of poverty. Many agencies are at present engaged in working out ways and means to secure laws to properly safeguard the poverty-stricken. It has come to be realized by the enlightened that poverty is a disease, and, as any other disease, needs medical attention. Therefore, the several agencies engaged in this most progressive movement prepared a memorial at the request of Senator Robert L. Owen for the purpose of point-

ing out the extent of the great national waste, due to disease, death and inefficiency; the best means of checking the waste, together with the work which is necessary to be done and the nature of the opposition to the establishment of a Public Health Department, which memorial he presented to Congress April 5, 1912, in conjunction with his bill advocating the establishment of such a department.

When one considers that the nation is allowing 1,500,000 lives to be lost annually and 3,000,000 lives to be constantly incapacitated, one only begins to realize the necessity of the National Government taking measures to check this undue waste and traffic in human bodies. One can only grasp the significance and the enormity of this loss when one considers that, expressed in figures, it represents an annual financial loss of approximately \$3,000,000. It is well known that acute diseases are responsible for a large portion of this loss, though happily waste from this cause is being gradually reduced. Chronic diseases are responsible for the largest part, whilst minor ailments and industrial accidents, so largely preventable, are responsible for a considerable item in this yearly orgy of waste in life, health and productiveness.

It cannot be denied that the undertaking is indeed herculean. The promoters of the movement for the conservation of human life will have to overcome much opposition before they realize their ambition. The education of the masses alone to the possibilities of eliminating disease is a task sufficient to dampen the ardor of those engaged in this magnificent work. The overcoming of legislative opposition would deter and discourage to the point of quitting the whole business those engaged in a movement of this magnitude except they know their cause is just. Dr. Dixon, commissioner of health for the State of Pennsylvania, says: "Why is our Government spending millions for the protection of forests and our coals? Why is it making strenuous efforts for the conservation of our water supplies and our natural resources? What is the object of hoarding all of these treasures which nature has lavished upon us if not for the service of man? Is it to the credit of our intelligence as a people that, while we give the guarding of these purely material interests a high place in our administrative scheme, we allow the man himself, without whom all is worthless, to remain unguarded by continuing to neglect to establish a National Department of Health to properly protect health, vigor and life, the greatest of all national assets?"

Medical Items.

DR. C. C. HASKELL of the Pharmacological Department of Eli Lilly & Co. was in attendance at the Atlantic City meeting of the American Medical Association.

DR. JOHN F. WINN of Richmond, Va., who for several years has filled the chair of clinical obstetrics in the University College of Medicine, and who has been closely identified with the obstetric department of that school since its organization, was further honored by its Board of Trustees in recent annual session, who elected him professor of obstetrics.

THE honorary degree of doctor of medicine was conferred upon Dr. R. Dorsey Coale, dean of the medical department of the University of Maryland, at the annual commencement of the University, June 1, 1912.

SEVERAL physicians who studied medicine in Baltimore are now practicing in Newfoundland. They are Drs. William Edward Jones, Avondale; Edward Gould Rowland, Badger; John J. Smith, Bishop's Falls; Clarence J. MacDonald, Bonavista; Walter A. F. Strapp, Harbor Grace; J. Burton Lynch, Lamaline; Archibald A. Chisolm, Manuels; Cecil Vernon Smith, Twillingate; William T. Scully, St. John's; William P. Hogan, St. Mary's, and Owen V. B. Smith, Tilt Cove. The majority of the physicians of Newfoundland were prepared for their work in Maryland, Massachusetts, Canada, New York and Scotland.

WILLIAM T. GOCHE, M.D., College of Physicians and Surgeons, '11, of Adamstown, W. Va., to Miss Clara Agnes Boyle of Johnstown, Pa., at Baltimore, May 29, 1912. Miss Boyle received her diploma as a nurse from the Mercy Hospital the evening preceding her wedding.

DR. JOSEPH W. SCANNELL, University of Maryland, '06, of Lewiston, Maine, has been much annoyed by Black Hand letters.

THE first commencement of the Training School for Nurses at the tuberculosis sanatorium at Sabillasville was held June 18 with the following eight graduates:

Misses Lydia H. Brauchie, Elise B. Jones, M. Maude Lee, Minola V. McQueen, Mary E.

Raley, Anna L. Shimek, Josephine T. Steigerwald and Mrs. Lucy G. Hayes.

The exercises were held in the new John Walter Smith Hospital of the sanatorium. Miss Emma Vaughan Johnson, a graduate of Johns Hopkins Training School for Nurses, is superintendent of nurses.

DR. WIRT B. WILSON, Maryland Medical College, '11, of West Virginia, has been elected superintendent of Franklin Square Hospital.

THE Maryland State Board of Medical Examiners report applications from 181 persons for licenses to practice in Maryland at their examinations June 18. This is the largest number ever examined in Maryland. Nine of those examined were women, and two of that number were colored.

DR. H. M. STEVENSON, for five years president of the staff of the Maryland Homeopathic Hospital, has, because of the demands of his practice, severed his connections with the institution.

DRS. J. M. T. FINNEY AND HUGH H. YOUNG are traveling in Europe.

THE annual meeting of the American Gynecological Society was held in Baltimore, May 29, 30 and 31. The visitors were entertained at the Johns Hopkins Hospital on May 30 by the superintendent, Dr. Winford H. Smith, and on the 31st at the Maryland Club as the guests of Dr. Howard A. Kelly.

THE explosion of a sterilizer at the Church Home and Infirmary slightly injured two nurses who were preparing instruments for an operation. Both are now fully recovered.

THE Maryland Medical College is planning the erection of a new building to adjoin Franklin Square Hospital, the new building to cost \$55,000.

THE graduating exercises of the Training School for Nurses of the Springfield State Hospital were held in the Women's Group, June 17, 1912. There were four graduates as follows: Misses Rosa Jeanette Collison of Anne Arundel county, Laura Etta Hitch of

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BALTIMORE

Worcester county, Susie Mary O'Brien of Howard county and Bessye Lee Wiley of Dorchester county.

"NEWSPAPER Advertising by Physicians" was discussed by the Baltimore County Medical Association at their regular monthly meeting, June 19.

ON JUNE 6, at Atlantic City, directly following the symposium on anesthesia of the American Medical Association, the National Society of Anesthetists was organized. Prof. Yandel Henderson of Yale, chairman of the committee on anesthesia of the A. M. A., occupied the chair, and those assembled for the symposium proceeded to organize and elected the following officers for the year 1912-13:

President, James T. Gwathney of New York; vice-presidents, Charles K. Teter of Cleveland, F. H. McMeechan of Cincinnati, Yandel Henderson of New Haven; secretary, William G. Woolsey, 88 Lafayette avenue, Brooklyn; treasurer, Harold A. Sanders of Brooklyn.

A committee was appointed to draw constitution and by-laws and report to the Society at its next meeting, and membership dues were fixed at three dollars for the first year.

The object of the Society is to develop the subject of anesthesia to greater perfection and more uniform safety, and the secretary will be glad to receive names of prospective members.

DR. T. MORRIS CHANEY of Old Fort, N. C., was a recent visitor to Baltimore.

THE merging of the Baltimore Medical College, College of Physicians and Surgeons and the University of Maryland is being discussed.

DR. AMERICUS ENFIELD of Bedford, Pa., is one of the most prominent members of the Pennsylvania delegation to the Democratic National Convention.

ENGAGEMENTS.

THE engagement is announced of Miss Mary Barton Saulsbury, daughter of the late Dr. and Mrs. Thomas Bascom Saulsbury, to Dr. James Hugh Bay, University of Maryland, '08, of Havre de Grace, Md. The marriage will take place in the early fall.

MR. AND MRS. WILLIAM M. WATKINS of Arlington, Md., have announced the engagement of their daughter, Louise Cecil, to Dr. Howard J. Maldeis, University of Maryland, '03, of 437 East 25th street, Baltimore. Miss Watkins was a pupil in the University Hospital Training School for Nurses.

MR. AND MRS. WILLIAM BARRETT RIDGELEY of Washington, D. C., announce the engagement of their daughter, Eleanor Cullom, to Dr. Henry Pickering Parker, Johns Hopkins Medical School, '96, now of Washington, but formerly of Baltimore. The wedding will take place in the autumn.

MARRIAGES.

CHARLES EDWARD WOODING, M.D., University of Virginia, '07, of Charlottesville, Va., to Miss Marie Early of Mount Fair, Va., June 19, 1912.

WILLIAM SHEPHERD HALL, M.D., University of Maryland, '99, to Mrs. Katherine Turner Kurtz, both of Baltimore, at Philadelphia, June 1, 1912.

JOHN SHAW GIBSON, M.D., University of Maryland, '05, of Gibson, N. C., to Miss Edna Iona Ebert of Baltimore, at Baltimore, June 12, 1912.

ROSCOE DRAKE McMILLAN, M.D., University of Maryland, '10, of Red Springs, N. C., to Miss Gertrude Anna Garrison of Burgess Store, Va., at Burgess Store, June 10, 1912.

HARRY DOWNMAN McCARTY, M.D., University of Maryland, '05, to Miss Mary M. DuBois, both of Baltimore, at Baltimore, June 24, 1912.

NEWTON WEBSTER HERSHNER, M.D., University of Maryland, '06, to Miss Wilma Anna Landis, both of Mechanicsburg, Pa., at Mechanicsburg, June 18, 1912.

DEATHS.

J. SMITH LINTHICUM, M.D., College of Physicians and Surgeons of St. Louis, Mo., died at his home June 12, 1912, after a prolonged illness. Dr. Linthicum was a brother of Dr. G. Milton Linthicum of Baltimore. He was 61 years of age.

HENRY B. DEALE, M.D., George Washington University, '87, of 1824 Jefferson street N. W., Washington, D. C., died at his home June 19, 1912, of angina pectoris, aged 50 years.

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THE TRIUMPHS OF PREVENTIVE MEDICINE.*

By Major Thos. L. Rhoads,
Medical Corps, U. S. Army.

THE field of Preventive Medicine is so great, and the triumphs of the workers in this field are so many, that it would take days to tell about them. So I will limit myself in the short time allotted this evening to speak of a few of the accomplishments in this line by the branch of the service to which I belong. The United States Army, while not a branch of the Public Health Service, has, through circumstances, been put in a position not only to aid the Government in solving its problems of national policy in regard to foreign and newly acquired territory, but its medical department has been confronted with the momentous task of cleaning up these territories, of controlling the death rate, and of making the places more habitable for their people and for immigrants from other countries.

It thus happens that the opportunities for public health work on a large scale which the events of recent years have forced upon the army were:

1st. The establishment of large concentration camps in the United States for troops, and the control of sickness among them.

2d. The military occupation of Cuba and the correction of its bad sanitary condition.

3d. The annexation of Porto Rico and the eradication of its prevalent diseases.

4th. The military administration of the Philippine Islands

*Address delivered at a public meeting of the Maryland Medical and Chirurgical Faculty, Baltimore, Md., February 21, 1912.

during the days of insurrection and the organization of the health department of the archipelago.

5th. The pacification of the Cuban Republic and the establishment of its health department as a ministry of the Government.

6th. The construction of the Panama Canal and the organization of the sanitary work that made the digging of the canal possible.

7th. The restoration of law and order in the great earthquake and fire calamity in San Francisco and the direction of sanitation in the wrecked city and the refuge camps.

We will pass over the days of the war in Cuba, for sickness and death in war time are inevitable, the morbidity and mortality among those in conflict are necessarily abnormally high, and the records of accomplishment of preventive medicine at some future date compared with war time days would be unfair. But let me take you back some ten or twelve years, a short period within the easy recollection of all, to Cuba after peace had been declared, and view its condition as it then was and note the transformation of its deplorable health conditions that took place under the several years of military control by the United States.

Cuba was a veritable pest hole. The streets of the cities were filthy, and in the majority of houses little was practiced, in fact little was known, of what we understand as modern sanitation. Open sewers were common, and it was not unusual for heavy rains to flood the deep cess pits under the house roofs and cause them to overflow. The public highway was the common receptacle for garbage and offal, and the common laws of health were generally disregarded. Many coffee, sugar and tobacco plantations had been abandoned in the years of strife of the inhabitants with Spain, and poverty followed in the wake of insurrection. Disease was a natural sequel, and there existed generally those diseases common to the tropics that spread with alarming rapidity when unrestrained by preventive measures. Malignant malaria or Cuban fever, as it was commonly called, was widespread over the island, and was the greatest cause of the existing morbidity. Uncinariasis, or hookworm disease, and other intestinal parasitic diseases, infected a large part of the population, and filarial disease caused many cases of elephantiasis. Leprosy was common, and in large measure unrestricted. So was syphilis. Smallpox alone had exacted a toll of 12,722 deaths in a single city—Havana—from 1870 to 1899. Yellow fever, however, was the great scourge, with 21,770 deaths to its credit in the city of Havana alone from 1870 to 1900, and at the close of the war it existed in its usual epidemic form all over the island. Such was the problem that confronted the medical department when the United States assumed military control to bring order out of the confusion that enveloped the affairs of the country.

With the establishment of a new system of government, the island was divided for administrative purposes into several military departments, under the direction of the commander-in-chief,

General Leonard Wood, as military governor, at Havana, and the sanitary work of the cities and districts was carried out by medical officers of the Army under the authority of the military department commanders. The larger cities, where the troops were stationed, necessarily demanded the first and most urgent attention, and the work of Colonel Gorgas in Havana is the best known, and may be accepted as a standard of what preventive medicine should be in the tropics; but other medical officers in the other cities and districts of Cuba deserve to be equally credited for the services they rendered to the whole world in making the island not only a healthful place for the native inhabitants, but a livable country for men from other climates.



YELLOW FEVER WORK IN CUBA.

Illustrating Captain Henry D. Thomason's method of fumigating a block of buildings. The canvas is spread over the entire block, and fumigation is carried on as in the case of a single building. In the early yellow fever work in Cuba it was customary for the sanitary squad to enter the infected house and seal the crevices in each room preparatory to fumigation. It was found that this practice disturbed the stegomyia and chased them to neighboring rooms and buildings. Captain Thomason's method has successfully overcome the danger of scattering the infected mosquitoes. The method likewise insures the complete destruction of all other animals in the buildings besides mosquitoes—flies, lice, bedbugs, rats, etc.

The then known means of sanitation were instituted to bring about a more healthful condition, and in a comparatively short time the general health of the citizens was in excellent state—save from one disease, yellow fever. Smallpox disappeared after vaccinating the island's population (there have been but three deaths since 1899); measures directed against malarial mosquitoes resulted in making malarial districts healthful; lepers were segregated and the disease prevented from spreading; intestinal diseases were investigated and carefully treated; sewerage

systems were inaugurated; garbage was thoroughly disposed of, and civic cleanliness was generally taught and practiced in this new era for Cuba. But with all this general sanitation, faithfully carried out, yellow fever began to claim its victims among the non-immune Americans, and the known means of sanitation seemed powerless to prevent its spread. It was then that a board was appointed by the Surgeon-General of the Army to meet at Camp Columbia, near Havana, Cuba, in May, 1900, to study the cause and prevention of yellow fever. The board consisted of Major Walter Reed, Surgeon, and Acting Assistant Surgeons Carroll, Agramonte and Lazear, U. S. Army. The work of this board became epoch making, and ranks with Koch's discovery of the tubercle bacillus, and the introduction of antitoxin for diphtheria.

This board carried out investigations based upon the theory of Finlay, and began to breed, dissect, classify and infect mosquitoes with yellow fever blood. Volunteers were called for to submit themselves to experiment; first to dispose the accepted belief held for 300 years that yellow fever was contagious by contact with the clothing, stools, etc., of a yellow fever patient, and second, to prove that the disease was conveyed to humans through the bite of a certain species of mosquito, the *stegomyia*, which had fed on yellow fever blood. The devoted self-sacrifice with which these young soldiers offered themselves as subjects for experiments for the good of humanity is a bright page in the records of American manhood. Some of these men, in addition to the experimental inoculation of yellow fever, in order to demonstrate that yellow fever could not be transmitted by infected clothing or other inanimate objects, submitted to being shut up in a house for twenty days, sleeping on the same beds, between the same sheets, on which yellow fever cases rested during their attacks, and wearing the very shirts that yellow fever patients had worn throughout their entire illness. In the light of the accepted knowledge of the day these acts required bravery of the highest order, and the information they gave was of the utmost importance to commerce, for it demonstrated that the methods of quarantine against the disease, as then carried out, were wrong, and they simplified immensely the preventive measures to be taken against the disease.

There were 22 cases of experimental yellow fever produced by the board, and 10 in the experiments carried on in Havana by Gorgas and Guiteras.

Digressing a moment, to give an idea of the frightful mortality of this disease in actual numbers, I make a few excerpts from the paper by Reed and Carroll, in 1901, on "The prevention of yellow fever." There have been 95 invasions of the United States by yellow fever during the past 208 years. There are no reliable data of the earlier epidemics, but there are of the epidemics which have occurred since 1793, subsequent to which date there have been not less than 100,000 deaths from this cause.

The appended table gives the number of deaths in some of the principal cities:

1. New Orleans.....	41,348	deaths
2. Philadelphia.....	10,038	"
3. Memphis.....	7,759	"
4. Charleston.....	4,565	"
5. New York.....	3,454	"
6. Norfolk.....	2,000	"

Estimating the average mortality at 20%, there must have been not less than 500,000 cases of yellow fever in the United States from 1793 to 1900. In addition to this number, during our brief occupation of Cuba, July, 1898, to December, 1900, there occurred 1575 cases of yellow fever in the army, with 231 deaths. The loss of life, however, is but part of the distress which our country has suffered. The pecuniary loss, not only in actual expenditure in the management of epidemics, but also the keeping up of expensive quarantine regulations, against which we are now insured, and the interruption of commerce with the quarantined region, are matters of serious moment. Dr. Horlbeck, chairman of the committee appointed in 1897 to investigate yellow fever, states in his report that the loss to the city of New Orleans alone, in the epidemic of 1878, was \$10,000,000, and the total loss to the country was \$100,000,000; and this was but a single epidemic. These figures give one an idea of how disastrous yellow fever has been to our own country, and of the magnitude of the service Reed and his board and his volunteers rendered our people.

The board, having established beyond doubt the exact method of transmission of yellow fever, preventive measures based on the discovery were at once undertaken in Havana, with the result that the disease which had appeared annually for some 200 years was completely wiped out. Like measures were instituted throughout the island, and on the withdrawal of the American troops from Cuba in 1902 the country was free of its two-century old scourge. Subsequent inability of municipal sanitary authorities to effectively carry out sanitary work, due largely to the poverty of some of the cities and districts, resulted in yellow fever breaking out anew in 1905 in scattered cases throughout the island, and when, in 1906, political disturbances made intervention by the United States necessary, and the Army of Pacification was landed, the army medical department again assumed the direction of the sanitary work of the island. The epidemic was stamped out after much labor, owing to the widely scattered cases, and the Department of Health for the island was organized by Colonel Kean, which organization has since maintained an effective health condition over the entire island. The death rate in the cities of Cuba is now no higher than that of cities in our country. Thus has Cuba been transformed from a pest hole and a menace to the health of the world to a country equally healthful with our own.

Now let us step across to Porto Rico and see what preventive medicine accomplished there. This naturally beautiful island, 100 miles long and 36 miles wide, with its delightful climate, its wealth of forests and fertile fields, had not been nearly so disturbed by the insurrection as had Cuba. Soon after peace with Spain had been declared the greater part of our invading army was taken away, and in the spring of 1899 there were but 5000 troops left behind. There was no systematic service of public health on this island, and its somewhat less than a million of population had for years been at the mercy of disease. Smallpox and yellow fever were endemic. Between December 15, 1898, and February 11, 1899, 554 cases of smallpox were reported from 16 different towns and villages in every direction, and it was not considered



YELLOW FEVER WORK IN CUBA.

Illustrating Captain Henry D. Thomason's method of fumigating a small group of buildings. The group is treated as a single structure.

to be any more prevalent at that time than usual. Intestinal parasitic diseases existed broadcast. A large majority of the island's population is composed of peasants, and 90 per cent. of these in 1899 were worm carriers, and were generally so heavily infected as to be worm sick. The reigning disease was an extremely prevalent and fatal anemia, and many of these pale, dropsical and debilitated subjects lived in unusually poor hovels, indigent to the last degree. The death rate of the population averaged 33.48 per thousand. To the medical officers of the small body of United States troops left behind fell the arduous task then of putting the Porto Rican house in healthful order, and of organizing its public health service on a permanent working basis. The first and most important duty undertaken, under

the direction of Colonel Hoff, the Chief Surgeon, was the vaccination of the whole population. This necessitated the manufacture of fresh vaccine in quantity, and a farm was established, young native cattle being freely offered by the farmers of the island for the use of producing vaccine. This, in itself, was quite a considerable undertaking, in the face of many difficulties, but the work was thoroughly carried out, and 859,017 vaccinations were made. The disease was suppressed in June, 1899, and has remained so. The same methods used in Cuba in combating yellow fever were applied here, and eradicated this disease.

In November of this year Captain Ashford, of the Army Medical service, made a discovery which meant much for the efficiency of the population and the material interests of the island. The relief of the severe anemia which affected the population generally became a serious problem to those in charge of the health work, and no appreciative effect on the disease was made by abundant and rich food and the usual remedies of iron, arsenic, etc. Dr. Ashford discovered that the anemia was due to an intestinal parasitic infection, the *Necator americanus*, or hookworm, and a systematic campaign of treatment was then organized to combat this prevalent disease. Laboratories were established for carrying on the work preliminary to treatment, hospitals and dispensaries were opened to receive patients, and by lectures and pamphlets the laboring classes, who were the principal sufferers, were educated to the necessity of presenting themselves for treatment. The good results with the early cases soon convinced the people of the island that they were dying of a curable disease; that the entire body of peasantry were threatened with invalidism, and that the malady could be successfully combated with safe remedies. The work was carried on successfully, and has since brought about the regeneration of Porto Rico. Half a million people have received treatment to date and have recovered, and a more comprehensive campaign is now under way which will doubtless rid the island of the disease. Porto Rico is a safe, healthful country to live in today, as the many Americans who seek its shores during our winter months can testify.

Now as to Panama. When the United States acquired, by purchase, the strip of territory, 10 miles wide, extending across the isthmus, from the Panama Government, for the purpose of constructing the great canal, there were few places on the globe residence in which was more fatal to human life than the canal zone. For nearly 400 years this neck of land had been the white man's grave. Commerce feared its ports—Colon on the Atlantic side and Panama on the Pacific side—for these cities were harbors of pestilence. In the interior morass and jungle, sun-scorched hills and swollen streams from a blistering sun and torrential rains, made the place a hot-bed for disease, and it was uninhabitable save to a few natives. The men of forty-nine, who sought to shorten the route to California by crossing the Panama Isthmus, fell easy victims to the country's maladies, and

buried their hopes with their bodies in desolate graves. When the 40 miles of railroad was finally completed across the isthmus in 1854 to meet the demands of travel, so many workmen had perished from disease that it became a common saying that every railroad tie represented the sacrifice of a human life. Then, in 1881, came De Lesseps and the French company to begin canal construction, and after coping with an awful death rate for 11 years, and expending \$250,000,000, the venture was finally abandoned. The defeat of the project cannot be attributed to exorbitant cost or to lack of engineering skill. France had the treasure and was enthusiastic in the enterprise, and De Lesseps had come exhilarated to his task after finishing the Suez Canal and saving mariners the circumnavigation of a continent. Comparatively



YELLOW FEVER WORK IN CUBA.

Illustrating Captain Henry D. Thomason's method of fumigating isolated buildings. The canvas covers the entire structure, and two (2) pounds of sulphur are used for each 1000 feet of contained space. The occupants are moved out in the morning, the canvas is spread, and fumigation is carried on for 8 hours. The canvas is then removed, the building is aired, and the tenants return in the evening.

little was accomplished in the way of a completed canal when the company gave up in despair to the dreadful epidemics among its workmen, and the graveyards and the fifty buildings devoted to hospital purposes left by the French bear testimony to the grim fight and defeat. In a period of five years the French company lost by disease eleven-sixteenths of its working force, and of seventeen engineers, officials who came in on one ship to assume charge of construction work, sixteen died. The contest, as we now know, was hopeless from the start, for the discoveries of preventive medicine necessary for the undertaking of such a task had not then been revealed.

In 1904 the United States took charge of the Canal Zone and began the work of canal construction. In order that the work might go on it was necessary, first of all, to protect those engaged in the work from disease, and to maintain a condition among them that would insure continuous and successful labor. Colonel Gorgas, of the Army Medical Corps, with the experience in sanitary work gained in Cuba, was the man selected for the task of making the zone habitable. This included not only the conversion of morasses and jungles into livable localities, and the eradication of diseases bred therein, but also the complete renovation of the two low-lying coast cities having a population of 50,000 people. This municipal renovation was a big undertaking in itself, for it meant the construction of underground sewers, with connections made with every building; the establishment of perfect surface drainage, the paving of streets, the screening of houses and receptacles for water, the rigid supervision of food and drink supplies, the general house cleaning of every building, and the regular inspection thereof; the extermination of rats—the carriers of plague—the scientific disposal of garbage, and the thorough inspection and treatment of the sick in order to protect the well.

Of major importance, however, for safeguarding the health of the 47,000 men that were to engage in the stupendous undertaking of canal building was the preparation of the 322 square miles of territory for habitation and the carrying on of unendangered work. The two prevalent diseases of the zone were malaria and yellow fever—malaria in its most malignant form, known on the isthmus as Chagras fever, and taking its name from the disease-breeding marshes lining the Chagras river. It took two years to make the necessary preparations before the work of excavation and construction could begin, but at the end of that time yellow fever had been banished from the zone and malaria had been controlled so as to allow the work to go on without thought of the dangers which made the French success impossible. The preliminary work in accomplishing this necessitated the establishment of laboratories to study the water supply, the infectivity of plants and insects, and especially to study the mosquito fauna. It was known at that time, of course, from the investigations that had been carried on in Cuba, that the *stegomyia* mosquito transmitted yellow fever, and it was likewise known that the *anopheles* mosquito transmitted malaria.

It may interest you to know the principles that governed the successful attack on these two diseases on the isthmus. First take yellow fever. In order to contract yellow fever one must be bitten by a *stegomyia* mosquito that has fed on the blood of a person sick with the disease during the first three days of his illness. Now, if every person developing yellow fever was at once isolated from any *stegomyia* mosquito, yellow fever would inevitably cease. So, also, if there was no access to men by any *stegomyia* mosquito in the infective stage, the same result would happen. Theoretically, then, yellow fever can be eliminated by controlling

either the patient or the mosquito, and as patients developing yellow fever can usually readily be diagnosed, and screened from mosquitoes, the first method, i. e., the control of the patient, would seem the more simple and feasible; especially so since the duration of the infective period—that is the period during which the patient can confer infection and be dangerous to his neighbors—is limited to the first three days of the disease, and the screening period would, therefore, be of short duration. But it was soon found that a perfect control of the patient was impossible under the conditions which existed, on account of the difficulty in finding the cases of yellow fever early in their course among the native population, and the failure of light cases being diagnosed and properly reported, especially among the native children. It became necessary, then, not only to control the patient by isolating him from mosquitoes by wire screening, and to destroy all mosquitoes that had access to him, or that by reason of environment created the presumption that they might have had access to him, but also to wage a general war of extermination of the *stegomyia* all over the zone by destroying their breeding places. The achievement aimed at was not to lessen the incidence of the disease, but to eradicate it. Obviously, if the territory could be made free of the disease, and at the same time free of the disease-carrying mosquitoes, the conditions would be most advantageous; for, looking at it from an economical point of view alone, no defense of quarantine would then be necessary should a case of yellow fever be introduced from some other port; the zone would be safe, as no communication of the disease would be possible, for, with no *stegomyia* mosquito to transmit the disease, yellow fever would be no more communicable than a toothache; and at the same time, with the result accomplished, the effort and expense involved in finding the sick, in isolating them, and in fumigating houses to destroy the mosquitoes which had access to them would be avoided. Accordingly, effort was concentrated on the destruction of the *stegomyia*. The breeding places of this mosquito are practically confined to water containers in the neighborhood of habitations, and the insect does not travel far from its home. The sanitary campaign waged began with the introduction of a water supply in pipes, and the digging of artesian wells, so as to do away with the necessity of storing water in cisterns, rain barrels, buckets, etc. The use of artificial containers for water was discontinued, and all pools and standing water in the vicinity of houses were thoroughly drained. It is interesting to note that the roof gutters, in which *stegomyia* mosquitoes were found to breed in quantity, were the last objects to receive attention, and the corrective measures directed against them marked the final disappearance of the *stegomyia* and of yellow fever from the zone in 1902.

Malaria fever offered a much more difficult problem. Like yellow fever, this disease is transmitted by a mosquito, the *anopheles*, of which eleven species were found on the zone. The

anopheles mosquito breeds in marshes and in pools and streams, in the grass and bushes, and these breeding places are often hard to find, and harder to destroy, and on the zone were distributed over the whole territory. The anopheles mosquito travels far from its breeding place, making it difficult to control the insect in the effort to eradicate the disease. It is also difficult to control the patient, for a person with malaria fever may be infective for a long time, and one accustomed to the poison may carry the plasmodium in his blood without symptoms, and will be a means of infection to others. Yet isolation of the malarial patient would obviously be impracticable. So the result aimed at with malaria was so to control the disease that it did not cause sickness or mortality beyond what would be permissible from an economic or humanitarian standpoint. With this end in view the preventive methods were: First—To prevent the breeding of anopheles by destruction of their breeding places. This included the filling up of low places, large areas of morass being covered in by train-loads of dirt excavated from the canal, and the digging of drains. Many portions of the zone are covered with a net work of miles of drains and ditches to carry off water from the marshes. These drains are tile lined, or cement lined, or rock filled, or simply open ditches, according to the demands of the soil condition.

Second—To kill the larvæ in breeding places that could not be destroyed. Coal oil and phinotas oil were used in large quantities in pools of large area and streams that could not be drained.

Third—To prevent the anopheles that escape destruction from having access to men. This included the screening of houses—not only of doors and windows, but the galleries as well—and the clearing off of bushes, high grass, etc., which would furnish shelter for the mosquitoes near dwelling-houses. Mosquitoes cannot live exposed to the hot sun, and grass cutting is a protection of value.

Fourth—In case anopheles have access to men, to arrange so that they have not had opportunity of previously becoming infected. This was accomplished by segregating the houses of the people to be protected from those of the natives and foreigners who have lived in the country for some time, and whose blood in all likelihood would be charged with malaria.

Fifth—To protect all employees with immunizing doses of quinine, so that even if they are bitten by infected anopheles mosquitoes they might not develop malaria. Three to six grains of quinine a day will at least lower the susceptibility of the men exposed and make them less liable to have malaria. The amount of quinine issued to the employees during a single year ran up as high as 3150 pounds.

By these methods malaria fever has been brought well under control on the isthmus, and with the stamping out of yellow fever, of smallpox, of plague, and of other preventable diseases, the canal zone has been converted from a home of pestilence to guaranteed security to the enthusiastic canal builders. The territory has now assumed, in all respects, the status of health belong-

ing to a well regulated community in a temperate climate. It can be truly said that in no locality has the evidence of sanitary progress or has preventive effort been more pronounced than here.

Preventive measures in the Philippines have brought good results similar to those achieved in Cuba, Porto Rico and Panama, though the problem there was in many ways different. After annexation of the islands in 1898 the army had an insurrection to deal with, in addition to a great public health work; progress in sanitation throughout the archipelago was necessarily tardy during the first few years, for discordant conditions required a gradual occupation of the many islands, and it took some time to win the confidence of the natives, inured to filth, and extremely



Swamp No. 4—Mount Hope, showing arrangement of open earth drains for swampy areas, Canal Zone, Panama.

suspicious, before they were willing to accept the American ideas of sanitation. The many large towns and villages presented conditions unspeakably filthy. Soil pollution was practiced generally, pigs acted as public scavengers, infected water supplies caused widespread sickness, and obnoxious garden methods aided in spreading disease. The duty of sanitation was imperative, for tropical diseases were rife among our troops, quartered as they were in such vacated convents and houses, etc., as the exigencies of the service offered, and subject to the nightly attacks of guerilla bands. Health boards were organized by the Army Medical Officers all over the archipelago; a general cleaning up of the islands was begun, and a campaign of education in sanitary matters was inaugurated, which has continued since July, 1901, under the auspices of the civil government. I will not go into

details of this work; suffice it to say that smallpox, fearfully destructive and fearfully prevalent in virulent form when we arrived, has been practically stamped out by vaccinating the 8,000,000 or more population; a crusade against rats resulted in the disappearance of bubonic plague; the segregation of lepers to the Island of Culion prevented the further spread of this disease; beri-beri, once a serious menace to health, no longer exists among the Government forces or among those people directly under Government control; regulations securing a proper and safe sewage disposal, together with inoculation with cholera lymph, greatly reduced the number of victims from cholera; and improving the water supplies reduced greatly the diseases dependent on intestinal parasites. In original research work the discovery of the transmission of dengue, by Ashburn and Craig, and the demonstration of the cause of beri-beri by Chamberlain and Vedder, stand out pre-eminently, and sanitary measures dependent thereon have been decisive. Much work has been done—there is still much to do in the Philippines—and with a continuance of the patriotism that has been displayed by the Americans in carrying on the sanitary work and the ambition to work for high standards, habitation in those islands should in time be as safe as it is in our own country.

With this record of achievement in public health work in recent years, a word as to what the army has done for itself, and I have done. You will recall the keen mortification suffered by the Army Medical Corps, as well as by all the American people, at the inability to prevent the devastating epidemics of typhoid fever occurring in the camps of mobilization at the time of the Spanish War—thirteen years ago. Twenty thousand cases of typhoid fever in an army of 120,000 men, with a case mortality of 7%, was the awful price of this disease. At the onset of the war it was the accepted belief that epidemics of typhoid fever were dependent on a polluted water supply, and that the furnishing of pure water would avoid infection with the disease. It took the experience of that war and a most thorough investigation to demonstrate that other factors—flies, dust, etc.—had to be considered in the transmission of the disease, and that they could, to a large extent, but not entirely, be controlled by scrupulous sanitation in camps where troops are concentrated. Accordingly, as all the factors in camp life could not be controlled, Major Russell, of the Army Medical Corps, set about to develop, by laboratory methods, some means of preventing the great havoc from typhoid. He determined upon a method of immunization against the disease by the injection of dead cultures of the typhoid bacillus into the subcutaneous tissues of the individual to be protected. The prophylactic was administered in three doses, with ten days' interval between each dose, and it was found that immunity against the disease was complete. Volunteers among the rank and file of the army later submitted to the treatment, with such success that immunization treatment is now compulsory in

the army, and typhoid, formerly our greatest dread, should, in the future, be a negligible menace to health.

A practical application of this discovery was given last summer when a maneuver division was assembled in Texas, on the Mexican border, and orders were issued for all officers and men of the command to be immunized with the typhoid prophylactic as rapidly as possible. The division was in camp from March 10 to August 7, 1911.

A contrast of the health record of this division compared with a division assembled under similar conditions of service in Spanish War time—that of the 2d Division, 7th Army Corps, organized at Jacksonville, Florida, about June 1, 1898, and remaining there in camp until October—speaks volumes. The two divisions were encamped in nearly the same latitude, for about the same length of time, and each had a pure water supply from artesian wells. No new sanitary principles were evoked in the management of the Texas camp, sanitary measures being executed with the same simplicity of method and thoroughness as in the Florida camp.

I quote from tables prepared by Colonel Kean, showing the morbidity and mortality from typhoid fever in these camps:

SECOND DIVISION, 7TH ARMY CORPS, FLORIDA, 1898.

Mean strength.....	10,759
Cases of typhoid fever.....	2,693
Deaths from typhoid fever.....	248

MANEUVER DIVISION, U. S. ARMY, TEXAS, 1911.

Mean strength.....	12,801
Cases of typhoid fever.....	1
Deaths from typhoid fever.....	0

The one case of typhoid fever in the Maneuver Division was a private in the hospital corps who had not completed his immunization, having taken only two doses. The case was very mild, and would, perhaps, have been overlooked but for the rule that blood cultures were made in all cases of fever continuing over 48 hours. His symptoms did not indicate typhoid. During the period of encampment 49 cases of typhoid, with 19 deaths, were reported as occurring in the city of San Antonio, adjoining the camp, and soldiers went to and fro freely in the city.

This discovery is one which has brought great satisfaction to the army, for it has robbed camp life of its one real terror, and the world should not look again upon such a picture as the camp at Jacksonville, or be heartsick with a second experience like Montauk Point.

In this record of accomplishment by the nation's military forces in preventive medicine, I know you take much pride, as we do, for, after all, we are of you, and merely represent you in a great Governmental work. These results have been obtained by organized effort, and may be accomplished in any place and in any community where a knowledge of sanitary science and intelligent

co-operation go hand in hand. Let everyone lend a hand in bringing this about!

LABORATORY METHODS. With Special Reference to the Needs of the General Practitioner. By B. G. R. Williams, M.D., Member of the Illinois State Medical Society, American Medical Association, etc. Assisted by E. G. C. Williams, M.D., formerly Pathologist of Northern Michigan Hospital for the Insane, Traverse City, Mich. With an introductory by Victor C. Vaughan, M.D., LL.D., Professor of Hygiene and Physiological Chemistry and Dean of the Department of Medicine and Surgery, University of Michigan, Ann Arbor, Mich. Illustrated with 43 engravings. St. Louis: C. V. Mosby Company. Cloth, \$2 net. 1912.

General practitioners are under an everlasting debt of gratitude to the Williamses for their textbook on "Laboratory Methods." Any publication which lightens the burdens of these physicians and points out a way to bettering their work is bound of necessity to succeed. Such a work is the above, for here one is given explicit direction how to carry out the ordinary laboratory technique with simple apparatus. It gives the reviewer, therefore, the utmost pleasure to set his stamp of approval upon their effort. The sun of the specialist is at last setting, to some extent at least. The men who go out of medical schools today are better than ever equipped to meet the ills of the human body, and with each year there is a greater number of men sent out into the practice of medicine who are not limiting themselves to any one special field. These men must have literature which will enable them to keep up with the advances of the times. The chaff must be separated from the wheat. The useful and practical must be placed before them in simple, non-technical phraseology. There is no doubt that the medical field is broad, and that one man cannot efficiently cover its entire aspect. But this does not signify that the day of the general practitioner is past; that there is no field for him; that he is a wart in the system. On the contrary, there are many avenues open to him, and he is only now beginning to readjust himself to the changed medical conditions. Such works as the one before us have influenced the general practitioner in finding himself, and have pointed out the feasibility of doing good work without the expensive equipment of the modern laboratory. Many of the most valuable contributions to medicine have been contributed by country physicians, and there is no reason why in the future the country doctor should not add to medical knowledge and do scientific work. Those who have had the pleasure and good fortune of having served an apprenticeship in a large hospital will attest the great respect they have acquired for the country doctor, who, laboring under insufferable difficulties, almost invariably bring in their patients properly diagnosed. Those who are going to practice in the country, or, for that matter, even in the city, will find this book an efficient aid in pointing the way to simplicity, practicalness and cheapness.

TYPHOID FEVER AND THE WAY TO PREVENT IT.¹

By C. W. G. Rohrer, M.D.,

Maryland State Department of Health.

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I. INTRODUCTORY.

THE invitation to deliver this lecture was hailed with delight. I accepted it with much pleasure. Nay, more, I have come with feelings akin to those which animate the pilgrim as he turns his footsteps toward the tomb of the Prophet.

The present betokens the dawn of a new era in preventive medicine. There has been a great public health awakening. Where ignorance and superstition once flourished, knowledge and reason now reign supreme. In no phase of the work has this influence been more keenly felt than in the department of hygiene, especially the hygiene of the transmissible diseases.

The topic designated for tonight, namely, "Typhoid Fever and the Way to Prevent It," is a very live one.² It is second only to a similar one which might be crystallized in the following words: "Tuberculosis: How to Prevent Its Spread."

Typhoid fever, like tuberculosis, is largely a disease of civilized life. It has only been recognized as a separate and distinct disease for the past 84 years. Prior to that time it was confused with *typhus* or ship fever, a disease unknown in Maryland at the present day.³

¹Paper read at the public mass-meeting held in Stern's Hall, Frostburg, Allegany county, Maryland, on Friday evening, May 3, 1912, at 8 o'clock, under the auspices of the Board of Health of Frostburg and the Civic Club of Frostburg. This meeting was held "for the purpose of bringing before the public certain information concerning the prevention of contagious and infectious diseases."

²The attached copy of a circular will explain the urgency for such a lecture in Frostburg:

TAKE NOTICE!

Whereas typhoid fever has been epidemic in certain locations in Frostburg during the past year, it behooves us to take every precaution in every way possible to eliminate liability to the disease.

Therefore, we submit to you the following advice:

Keep everything clean about your premises in order to keep the flies away from your houses, as undoubtedly the fly is the typhoid carrier in this vicinity.

Procure good screen doors and windows and use them. They cost less than funerals.

We also strongly advise people living in the typhoid territory to submit themselves to typhoid vaccination during the month of May and June.

Typhoid vaccination has the effect of protecting the person from contracting the disease for a period of about three years. It has proven successful in nearly all cases. By order of the BOARD OF HEALTH OF FROSTBURG.

These bills will be distributed through the courtesy and kindness of the Civic Club of Frostburg.

³Typhus fever was formerly a deadly epidemic disease in Maryland. The word *typhus* means "sleepy"; *typhoid* means "like typhus." The last cases of typhus fever in Maryland occurred in May, 1901. These were imported cases, three in number, one of which resulted fatally.

II. SPECIFIC CAUSE.

Typhoid fever is a germ disease; that is, it is caused by microbes or germs. The special germ which produces typhoid fever is called the typhoid bacillus, because it is shaped like a small rod. It is so minute that it can only be seen clearly when examined under the microscope and magnified from 600 to 1000 times. It is about $1/12,000$ of an inch in length, and about $1/36,000$ of an inch in thickness. The discharges from a typhoid fever patient contain millions of these germs.

I know there are still a few persons who do not believe in germs, but I trust there is none such in the enlightened town of Frostburg. Because typhoid fever is caused by a germ, we call it an "infectious" disease. Because the disease is only propagated and spread by the germs passing from one person to another, we speak of it as a "communicable" disease.

We stand appalled when we think of the terrible *Titanic* disaster, the most distressing one recorded in the annals of maritime history. A total of 1635 persons fill a watery grave as a result of this great calamity, which involves two of the greatest nations on the face of the globe. Yet these 1635 persons are but a mere handful, compared with those massacred annually by the typhoid bacillus. In the United States of America alone, 35,000 persons die each year of typhoid fever, and over 400,000 of the flower of the nation are sufferers from this disease. In the State of Maryland, the "Old Line State," one of the most advanced and progressive States in the Union in many respects, an average of 350 deaths⁴ result each year from typhoid fever. But it should be added, to the lasting credit of the Baltimore City Health Department and the Cumberland Board of Health, that these two cities, Baltimore and Cumberland—the largest two in Maryland—are to be exempted from the foregoing statement, because both Baltimore and Cumberland, under the judicious administration of their respective health officers,⁵ have effected a very creditable diminution in their typhoid morbidity and mortality.

I would that the same good report might be said of numerous other cities, towns and rural communities throughout the State. An explanation is not far to seek. Just as the faithful physician is the last to receive emolument in the settling up of an estate, so when all other provisions have been made in a town or city government, if a modicum of energy is left it is infused into a provisional board of health, with perfunctory duties and unpaid members, which board probably never holds a single session throughout the year.

However, I am optimistic on this subject, one that is fraught with much greater importance than the public at large seems to realize. To mention figures in support of my opinion I desire to

⁴This applies only to rural Maryland, the total for the entire State being 3181 cases of sickness, with 503 deaths, in the year 1911.

⁵Dr. James Bosley is Health Commissioner of Baltimore, and Dr. Francis E. Harrington is Health Officer of Cumberland. Dr. C. Hampson Jones is Assistant Health Commissioner of Baltimore.

give the following, taken from "Maryland's Annual Typhoid Problem."

TABLE NO. 1.—ANNUAL DEATH RATE FROM TYPHOID IN MARYLAND.

Census year.	Population.	No. of deaths.	Death rate per 10,000.
1880	934,943	716	7.66*
1890	1,042,390	476	4.57
1900	1,188,044	526	4.43
1910	1,294,450	544	4.21

These figures comprise the total for all Maryland. In quoting public health statistics we usually divide the State into two jurisdictions:

1. The city of Baltimore.
2. Rural Maryland—the entire State of Maryland, exclusive of Baltimore City.

The next table will give the statistics for rural Maryland. These do not compare as favorably as the ones given in Table No. 1. They indicate that much yet remains to be done in the smaller cities and towns and in the rural districts in the suppression of typhoid fever.

TABLE NO. II. TYPHOID IN THE COUNTIES OF MARYLAND.

Year.	Estimated population.	Cases of sickness.	No. of deaths.	Death rate per 10,000.
1907	733,335	969	295	4.02
1908	741,397	1,647	350	4.72
1909	749,537	1,977	294	3.92
1910	757,767	2,348	309	4.08
1911	742,891	1,980	349	4.70

The spirit manifested at this meeting shows that the people of Frostburg are wide awake to the occasion—that of diminishing the prevalence of typhoid fever. As a basis for our campaign, we might frame the following postulate: *Every case of typhoid fever comes from a previous case of typhoid fever.*

Only human beings are subject to typhoid fever. Fortunately for us, animals are exempt from this disease. But many times animals serve as carriers or disseminators of typhoid. Among these should be mentioned:

1. The house-fly and other insects.
2. Domestic animals.

The house-fly is far and away the most important insect conveyor of the typhoid virus. Domestic animals pale into insignificance when compared with the house-fly as propagators of the deadly typhoid.

Typhoid fever is sometimes called "drain" fever, because of its almost invariable connection with defective drainage. Where typhoid fever prevails to any extent, you always find the trinity—

*These figures are excessive, and doubtless include deaths from typhus fever, "typho-malarial" and other hybrid diseases.

defective sanitation, defective drainage and defective public health regulations.

Public health in Maryland is yet in its infancy. For years the subject was tabooed and ignored and hampered by reason of insufficient appropriation. But times have changed, and public health matters are rapidly forging to the forefront of momentous State questions. An enormous stride was made just yesterday, when steps were taken toward the organization of a Bureau of Sanitary Engineering⁶ in the State Department of Health, and I am most happy to make the announcement. Such a bureau is really the only one predestined to aid in the prevention of disease rather than its interception after it has once gained a foothold in a community. One of its avowed functions is to guide and direct you in such work as you performed on Wednesday, the first instant, when you were endeavoring to make Frostburg a spotless town.⁷

In order to contract typhoid fever, the germs must enter your stomach and intestines by way of your mouth. This is usually effected through the medium of food or drink. But there are other ways in which typhoid germs may gain entrance into the human alimentary canal.

III. AVENUES OF INFECTION.

There is but one real avenue of infection—the mouth. But, as all roads formerly led to Rome, so do all highways and byways of typhoid infection lead to the human mouth. These may be grouped under some four or five appropriate subheadings, as follows:

1. Infection by means of the drinking water supply.
2. Infection through contaminated milk.
3. Infection through raw foods and vegetables.
4. Infection through the agency of flies and other insects.
5. Infection by means of direct contagion or contact.

There are other avenues of infection of lesser consequence which will be considered also in the body of this paper.

⁶A Bureau of Sanitary Engineering in the State Department of Health of Maryland was organized on Thursday, May 2, 1912. Mr. Robert B. Morse of the Metropolitan Sewerage Commission, New York City, was elected chief of the Bureau. Mr. Morse, however, did not assume the duties of his office until June 1.

⁷The nature of this work was embodied in a circular, of which the following is a true copy:

PROCLAMATION!

In continuation of the movement begun last year for a clean town, I hereby request all property owners and tenants within the corporate limits of Frostburg to

CLEAN THEIR PREMISES ON WEDNESDAY, MAY 1, 1912.

of all Garbage Accumulations, Remove all Animal and Vegetable Matter from Outhouses, and do whatsoever else in this direction that may be necessary to secure for themselves and their neighbors absolutely sanitary conditions and surroundings—all within the day named, if possible.

☞ All refuse should be conveniently placed for loading and quickly hauled away at expense of property owners.

With our prestige for healthy altitude and pure atmosphere, let us combine the next essential element to make this a model town—*complete and continuous cleanliness.*

JOHN J. PRICE, Mayor.

A majority of the cases of typhoid fever are due to contaminated drinking water. It would be a conservative estimate to say that at least two-thirds of the cases are so caused. How do the typhoid germs get into the drinking water?

With our present lax methods of sanitation, this is a comparatively easy task. Occasionally a solitary case of typhoid fever will occur in a household which cannot be definitely accounted for. But where two or more cases occur in a family we almost invariably find a surface well contaminated by a surface toilet. In fact, I have chosen to brand these two—the surface well and the surface toilet—as the “Siamese twins in the causation of typhoid fever.”

The *modus operandi* is as follows: Someone who is developing typhoid fever comes along and unwittingly uses the surface toilet. It may be one who has just recovered from an attack of the disease. In either instance the typhoid bacilli, liberated from their human host and deposited upon the surface of the ground, become a more deadly foe than the rattlesnake or the vituperous copperhead. The second act in the drama is the occurrence of a freshet, which causes the typhoid discharges to seep into the earth and eventually reach the water-bearing strata, or the infectious material is washed directly into the well unprotected from surface pollution. Two or three weeks later the curtain rises to the third act—the development of typhoid fever among those using water from the infected well.

The above is no fiction. On the other hand, it is a terrible truth—a heart-rending scene acted annually in almost every city, town and rural community throughout the length and breadth of the State. To add to the terrible picture, we must bear in mind that *typhoid fever is distinctly a preventable disease.*

There are other routes of infection and other diseases disseminated through the medium of that hydra-headed monster, the surface toilet. The infectious material may be carried into the home by the feet of men and domestic animals. Dogs, cats, swine and poultry are also occasionally responsible. But the house-fly, called by Dr. L. O. Howard the “typhoid fly,” and by Dr. Charles Wardell Stiles the “filth fly,” finds in human excrement an ideal breeding place and feeding place. From it the house-fly goes forth, bearing untold millions of typhoid germs upon the exposed surface of its body and in its intestinal canal to cause a harvest of death among those living in the houses nearby.

To summarize the recent paragraphs. We find the three following to be potent factors in the propagation of typhoid fever:

1. The surface toilet.
2. The surface well.
3. The house-fly.

The above work in unison. One seconds, as it were, the nefarious work of the other. Therefore, to rid Maryland of typhoid

fever, the surface toilet should be abolished.⁸ It has been determined that typhoid germs are able to live for over a year in a surface toilet. The surface toilet should be superseded by the box toilet, kept scrupulously clean in country places; in towns and villages nothing short of a modern sewerage system should suffice.

But the surface well—what shall we do with it? From time immemorial our forefathers drank from its cooling depths. It will aid very materially if we renovate the surroundings of the well. But the whole principle is notoriously wrong. In the “dim and distant past,” when the country was but sparsely settled, the danger of contamination was reduced to the minimum. But times have changed, and the segregation of mankind into populous communities has rendered the drinking of water from surface wells at certain seasons of the year well-nigh suicidal. The name “surface well” itself is highly significant. It portends that it is little other than the slimy pool, deepened and encased with brick and allowed to stand a sufficient time to bring about sedimentation. Under such conditions typhoid bacilli readily gain access to surface wells, wherein they retain their vitality for a period ranging from one to six weeks.

The third great typhoid disseminator, the house-fly, is very well taken care of nowadays by the Women’s Civic Leagues. A goodly portion of the late fall crop of flies hibernate, or in large measure suspend animation, during the winter months, to awake from their sleep with the dawn of spring. In the springtime the surviving flies come forth from their hiding places in a very weak and enfeebled condition. They usually spend 10 days or two weeks in copious feeding, trying to regain their lost vitality. They are then ready to propagate their kind. Hence it can be seen that a few flies destroyed in April will mean many millions less during the heat of summer.

The present season has been a noteworthy one. The winter just over was the coldest in the memory of man. Many flies perished from the extreme cold. The spring crop of flies is thus necessarily short. In addition, there have been two other factors inimical to fly-growth. These are as follows:

1. The late, cool spring.
2. The extremely wet weather.

The chief step toward fly-extinction is undoubtedly the killing of the parent flies in April, or, as in the present year, in the month of May. Important auxiliary measures, not to be omitted by any means, are:

1. The screening of toilets. These should also be provided with lids.
2. Allow no manure heaps in the vicinity of dwelling-houses. Horse manure is *facile princeps* as a breeding place for flies.⁹

⁸The surface toilet was abolished in Chestertown, Kent county, Maryland, on September 1, 1909, by order of the Board of Town Commissioners. Box toilets, to be cleaned at stated intervals, were recommended.

⁹During late spring and summer of the current year I have had the unique experience of rearing house flies in the excrement of the American wildcat (*Uncia rufus*), and also in that of the groundhog (*marmota monax*). In both of these the flies thrived amazingly.

3. Garbage should not be allowed to accumulate. Garbage cans should be provided with tight covers and emptied at regular intervals.

4. Rubbish heaps, consisting of sticks, stones, old rags, paper, tin cans, etc., should not be tolerated.

Flies are short-lived. Ordinarily, the span of life of a house-fly is but three or four weeks. The female lays two or three batches of eggs, numbering about 120 each. These are usually deposited in a heap of horse manure, in human excrement, poetically known as "night soil"; in garbage and other refuse.

IV. METHODS OF PREVENTION.

In the prevention of typhoid fever the old adage that "cleanliness is next to godliness" is productive of more good than all other measures combined. Typhoid fever is largely a filth disease. A "clean-up day," such as has been advocated by the Maryland Associated Boards of Trade, is the first and best step. In this manner the pollution of wells will be reduced to a minimum, and practically all breeding places for flies will be destroyed.

Boiling the water used for drinking and culinary purposes when typhoid fever prevails is another excellent preventive measure. Drinking water may be distilled and rendered safe, or rendered reasonably safe, by filtering.

The milk supply is important in combating typhoid fever. The investigation should extend from the dairy farm to the home of the customer. Milk-borne epidemics of typhoid fever occasionally occur, some of a virulent type.¹⁰ All of these could be warded off by a little judicious inspection of dairy farms at regular intervals. Such an inspection would comprise:

1. Inspection of the dairy farm itself—its location, drainage, water supply, status of inhabitants—their general health, especially with reference to present or past attacks of typhoid fever, or even any indefinite intestinal derangement of 10 days' duration or more.

2. General health of those doing the milking and working about the dairy.

3. The proper cleansing and sterilization of all milk bottles and other utensils used about the dairy. Milk is a valuable medium for the cultivation of the typhoid bacillus.

4. Supervision of the health and habits of those driving the milk wagon and delivering the milk.

5. Forbidding the leaving or collecting of milk bottles from homes where typhoid fever is present. The family should provide a receptacle into which the milk or cream can be poured. This is applicable to all infectious diseases.

6. Forbidding the washing of milk cans with water from an infected well.

¹⁰The first recorded milk epidemic of typhoid fever in Maryland occurred in Elkton, Cecil county, in July, August and September, 1884.

7. Instructions to keep the dairy well protected at all times from flies.

By this time it must be clear to everyone that typhoid germs enter the milk from without. They are not in the milk when it is drawn from the cow. They are conveyed to the milk by the hands of the milkers, by the hands of someone employed in the dairy or through the instrumentality of flies. Washing the cans with infected water is another very potent source of danger. In no instance should milk be sold for human food when typhoid fever prevails on the dairy farm until the patient has been removed to a hospital and the dairy renovated and given a clean bill of health by the local health officer.

Next to an infected drinking-water supply, infected milk is entitled to the gravest consideration as a conveyor of the typhoid infection. Boiling a suspicious supply of milk will render it harmless. Pasteurization will also effectually destroy the typhoid bacilli, which are not very resistant to heat.¹¹ Even ice-cream may contain deadly typhoid germs, which have entered through infected milk or from the hands of the ice-cream manufacturer or dispenser.

Raw vegetables and fruits may convey the contagion of typhoid, infected in one of the following methods:

1. By the use of "night soil" as a fertilizer.
2. By washing in infected water.
3. From the hands of the dispenser or servant.

Washing the raw vegetables and fruit in hot water will minimize the danger or dispel it entirely.

Bread, cake, pies, pastry, etc., purchased from sources where typhoid fever exists, unless proper precautions are taken, may convey the infection.

Finally, before closing the present section of my lecture, I desire to discuss a means of prevention which is surest of all. It is anti-typhoid vaccination, or inoculation against typhoid. This method is so exceedingly simple and so uniformly successful that I hereby recommend it without any reservation whatsoever. It has been thoroughly tested, both at home and abroad. Its successful use has wrought wonders in the United States Army; it has been advocated by the Secretary of the United States Department of Agriculture. Here in Maryland my colleagues, Dr. H. W. Stoner and Dr. F. W. Hachtel, of Baltimore, have tabulated the results of this method of prevention upon between 1600 and 1800 individuals who have been inoculated against typhoid with vaccine prepared by them. Stoner and Hachtel's results show a uniformity of success which must be convincing.¹²

¹¹The thermal death point of the typhoid bacillus, according to Sternberg, is 56 degrees C. in ten minutes.

¹²Vide Hachtel and Stoner's paper, "The Use of Antityphoid Vaccine in Public Institutions and Among Civilians," published in the *American Journal of Public Health*, March, 1912.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor*.

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BALTIMORE, AUGUST, 1912

BUBONIC PLAGUE: A POSSIBILITY.

WORD has been received that bubonic plague is prevalent in the islands close to our shores. Cases of true bubonic plague have been reported in Santiago, Cuba, and other cities near our coast. Several years ago there was an epidemic of this disease in San Francisco, Cal., which was only stamped out at great cost and energy. At that time the director in control of eradication was Dr. Rupert Blue, now Surgeon-General, United States Public Health and Marine Hospital Service. He waged an energetic and successful fight, and also warned the Eastern cities by a statement that they might at any time expect to be visited by a like calamity unless they took measures to banish the rat. This notice has not been heeded, and with the disease so close at hand its presence amongst us may be expected at any time. Eternal vigilance is the price of success. In this case is meant the banishment of the rat. For plague is primarily a disease of rats, whence it is conveyed to man by rat fleas. The method of elimination of the disease is therefore obvious. Get rid of the rats. The destruction of rats gets rid of the fleas, and as fleas are a necessary link in the chain of conveyance of the affection from rat to man, the disease cannot be carried. Dr. Blue during his San Francisco experiences proved the possibility of the eradication of the rat. He accomplished this apparently impossible task first by starving the rodent. This was done by placing household waste and garbage—the food of the rat—in air-tight metal garbage

cans with tight-fitting lids. Particular attention must be paid to this detail, and no waste or possible food must be left about the dwelling. The premises must be kept scrupulously clean. Boxes, waste, rags, etc., which offer a harbor, must be removed, so that the animal cannot find a place of concealment. Render the rat homeless. Force him out of his burrows under old buildings and planks. Compel him to come out into the open, where he will be easy prey to dog or cat. The dog will be found especially valuable in the work of destruction. If the harboring places of the rat are destroyed, his elimination is an easy matter. Old plank walks should be taken up and replaced with concrete. Dirt-floor cellars should be concreted. Back fences, which afford a convenient run, should be taken down. The stable is a favorite home for rats. The manure affords a warm and comfortable nesting ground, and the food bin a plenteous source of food. The plank floors should be replaced with concrete, the grain kept in metal-lined bins, and the manure should be stored in metal-lined or concrete pits and removed at least once in every eight days. One of the greatest drawbacks to the control of plague in San Francisco was the constant addition of infected rats from newly-arriving ships. This obstacle was overcome by placing wire screens over the sewer outlets. The grocery shop, the market, the butcher shop are under present conditions infested with rats, as they offer an abundance of provender. San Francisco proved, contrary to public opinion, that ratproofing was possible in these establishments. "A wise old rat" is a common saying, and there is no doubt but that the rat is a cunning animal and full of resources, but a starving rat is not so particular as to his food. In better times he will pass by poisoned tidbits, but in dire distress and an empty stomach such a little thing as poison in food is apt to be overlooked. New Orleans and Norfolk are alive to the possibility of the introduction of plague into their ports, and have taken time by the forelock. The health authorities of those cities are paying five cents for every rat head brought to the department. It is not amiss that the Board of Health of Maryland, and especially that of Baltimore city, start a campaign for the destruction of the rat, and thus limit the likelihood of the appearance of the plague. For without the rat there can be no plague.

Medical Items.

DR. PAGE EDMUNDS has been appointed associate professor of genito-urinary diseases at the University of Maryland; Dr. Richard H. Johnston, associate professor of diseases of the nose and throat, and Dr. William Tarun, associate professor of diseases of the eye and ear.

DR. AND MRS. WILLIAM CUTHBERT LYON are spending their honeymoon abroad.

DR. J. M. T. FINNEY is spending some time near Hamburg, Germany.

DR. RANDOLPH WINSLOW sailed for Panama July 13.

DR. JOSEPH COLT BLOODGOOD, who was operated upon for appendicitis recently by Dr. Richard H. Follis, is said to be improving. Dr. Bloodgood is a patient at Johns Hopkins.

DR. LEO BRANDENBURG was appointed resident physician of the Maryland General Hospital at a meeting of the board of directors held the first week in July. Dr. R. Chitwood, Baltimore Medical College, '12, was appointed a member of the medical staff.

DR. A. L. BLANCHETT of the Maryland General Hospital is away on a vacation.

THE old home of the Atlantic Medical College has been transformed into the new Skin and Cancer Hospital of Baltimore, the first institution of its kind south of New York and the fourth of its kind in the United States. The new hospital was formally opened by the Mayor of Baltimore on July 8, 1912. The "White Hospital," as it is nicknamed, can care for 50 patients—16 in private rooms, 14 in private wards and 20 in public wards. The entire equipment of the hospital is of white enamel, including the bureaus, washstands, beds, chairs and rockers, as well as all the walls. The floors are stained a dark mahogany.

DR. ALBERT H. CARROLL has returned from a visit to Atlantic City.

It is reported that Dr. Henry C. Ohle, 1205 West Fayette street, who lost his sight two years ago from an infection, is now gaining ground and hopes to be able to see fully within the next few months.

DR. HARVEY CUSHING is traveling abroad, and Dr. John Ruhrah will sail shortly for a Continental trip.

DR. Z. C. MYERS, 278 West Market street, York, Pa., was operated upon recently in the University Hospital, and is reported to be doing nicely.

THE County Commissioners of Washington county re-elected Dr. Jephtha E. Pitsnogle health officer of Washington county at an annual salary of \$900 and expenses.

DR. WILLIAM J. COLEMAN has been reappointed superintendent of the University Hospital.

THE Mothers and Infants' Department of the Henry Watson Children's Aid Society will complete its second year's work October 31, 1912. This work is of interest to the medical profession from the standpoint of after-care for unmarried mothers. During the past 18 months 354 mothers who would have gone out of the hospital to face an unfriendly world without a constructive plan for their future have been reinstated and guided to industrial independence. The delicate task undertaken by social workers involves sympathy, interceding with relatives, finding employment which enables the mother to keep her child, and subsequent supervision. The results are most gratifying. The infant mortality for the first year was less than 2 per cent. Mothers who have had more than one child, when given an opportunity to live self-respecting lives, have developed into fond mothers and efficient workers. The department has had the co-operation of the Maryland Society for the Study and Prevention of Infant Mortality. Drs. J. H. M. Knox, J. Whitridge Williams, J. M. H. Rowland, Flora Pollack, E. H. Kroman and others have given much valuable assistance to the work. The work is entirely sustained by voluntary contributions. An effort is being made to raise \$1000 to meet the necessary expenses to October 31, 1912.

DRS. C. H. AHROON, S. J. Crowe and C. H. Jones are traveling abroad.

DR. H. S. GREENBAUM has just returned from an European trip.

A RURAL weekly observes that Mrs. J. S. is under the care of a very prominent doctor, and is in a very precarious condition with a "drop-sical effection and other troubles in her leg and bad liver." We sincerely hope she recovers, and would like to see the case report.

THE following changes are announced in the faculty of the Johns Hopkins Medical School:

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BALTIMORE

Dr. Herbert M. Evans, now associate, to be associate professor of anatomy; Dr. Charles R. Essick, now instructor, to be associate in anatomy; Dr. Thomas R. Sprunt, now instructor, to be associate in pathology; Dr. Samuel J. Crowe, now assistant, to be associate in surgery; Dr. Lloyd P. Shippen, now assistant, to be instructor in hygiene and bacteriology; Dr. Henry A. Stephenson, now assistant, to be instructor in obstetrics; Dr. David M. Davis, assistant in pathology; Dr. Henry H. Hazen, assistant in dermatology; Dr. Geo. B. Jenkins, assistant in anatomy; Dr. Roy D. McClure, assistant in surgery; Dr. Holland N. Stevenson, assistant in pathology, and Dr. Everett D. Plass, assistant in obstetrics.

DR. WILLIAM H. WELCH gave a dinner at the Baltimore Country Club on June 9 in honor of Surgeon-General Torney, U. S. A.; Col. William C. Gorgas, U. S. A., and Surgeon-General Rubert Blue, U. S. P. H. and M. H. S.

THE Baltimore City Medical Society has appointed a permanent honor committee, composed of Drs. Gordon Wilson, J. Whitridge Williams and Wilmer Brinton, to investigate all unethical proceedings and prefer charges against all offenders before the board of censors.

THE chair of anatomy in the University of Maryland will hereafter be held by an incumbent, who will devote his entire time to his duties, and who will not be allowed to practice. His salary will be \$3000 per annum.

DR. GEORGE B. REYNOLDS, who was assaulted by sandbaggers while returning from a visit to a patient in May, is reported to be completely recovered.

DR. HAUGHTON BAXLEY is reported to be critically ill with erysipelas.

THE new building of the Maryland Asylum and Training School for the Feeble-Minded at Owings Mills was opened and inspected June 28. The building is of stone, and, together with two other buildings, cost \$75,000. It contains appliances for teaching manual training, several lecture-rooms and an assembly-hall, with a seating capacity of 500.

DR. HOWARD A. KELLY gave a dinner on June 20 to Baltimoreans interested in moral and

sanitary prophylaxis work. Plans were considered for reforms in certain sections.

WASHINGTON AND LEE UNIVERSITY has conferred the honorary degree of LL.D. upon Dr. Thomas A. Ashby; the University of Michigan, those of Doctor of Science and Doctor of Laws upon Drs. John J. Abel and William H. Howell, respectively; the University of Ohio, that of A.M. upon Dr. Charles F. Blake, and Loyola College, those of LL.D., A.M. and A.B. upon Drs. Charles O'Donovan, Leonard K. Hirshberg and Emil Novak, respectively.

THE regular meeting of the Baltimore County Medical Association was held in Towson, July 17, 1912.

MARRIAGES.

LOUIS E. LANGLEY, M.D., University of Maryland, '10, of Williamsport, Pa., to Mrs. Nora L. Burke of Centreville, Md., at Baltimore, June 29, 1912.

HUGH RAYMOND SPENCER, M.D., Baltimore Medical College, '10, of 1302 Linden avenue, Baltimore, to Miss Lillian Estella Elliott of Baltimore, July 6, 1912.

CLARENCE B. FARRAR, M.D., Johns Hopkins Medical School, '00, of Walbrook, Md., to Miss Evelyn Linwood Lewis, at Alexandria, Va., September 15, 1911. At home, July to October, Mont Alto Groves, Walbrook, Md.

DEATHS.

RINGTON DAVIS, M.D., Ohio Medical College, died suddenly at Brighton, England, aged 56 years.

JOHN W. FIELD, M.D., University of Maryland, '60, died at his home in Chincoteague Island, May 4, 1912, aged 75 years.

GAIL SAMUELS, M.D., Baltimore University School of Medicine, '97, died at his home in Parkersburg, W. Va., May, 1912.

GEORGE R. PATRICK, M.D., University of Maryland, '79, died at his home in Lowell, N. C., June 19, 1912, of cerebral hemorrhage, aged 57 years.

WILLIAM STOKLEY, M.D., died at his home in Seaview, Va., July 11, 1912, aged 61 years.

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NOTE.—Owing to the wide interest in the article by Dr. Mackenzie and the numerous requests we have received to reprint the paper, it is again presented in this issue of the JOURNAL.

THE MASSACRE OF THE TONSIL.*

By John N. Mackenzie, M.D.,

Clinical Professor of Laryngology and Rhinology in the Johns Hopkins University
and Laryngologist to the Johns Hopkins Hospital.

DURING the past few years I have been repeatedly urged by medical friends to give some public utterance by way of formal protest against the indiscriminate and wholesale destruction and removal of the tonsils, which, far above all others, is the chief and most glaring abuse in the laryngology of the present day. They have been good enough to say that a word might not be amiss from one who has been through the dust and heat of the conflict that has raged around this and other fancies in surgical laryngology which have risen and fallen during the quarter of a century that has just passed away.

One of these friends, a distinguished general surgeon of wide experience, large practice and exceptionally high professional skill, in insisting that I say something on the subject, gave me as his deliberate opinion that of all the surgical insanities within his recollection this onslaught on the tonsils was the worst, not excepting the operation on the appendix. And, indeed, when I look back through an experience of over thirty years, in which I have seen theory after theory, for some of which I have been partially, if not wholly, responsible myself, come and go, materialize and dissolve, I feel that, notwithstanding the fact that I approach the subject with reluctance, with diffidence, with hesitancy—with even timidity—and fully mindful of the truth that we are all liable to error, even the youngest of us, and that nowadays in some quarters apparently age and experience count for nothing, I feel I may be pardoned for saying a few words in what I consider to

*Read April 24, 1912, before the Medical and Chirurgical Faculty of Maryland.

be the interest of the public health, and, therefore, of the public safety.

Let me at the outset be not misunderstood. It is not my object to stir up strife, to impute unworthy motives to anyone, or to arrogate to myself any superior wisdom in the surgical management of tonsil disease.

Nor do I wish to shift to other shoulders all the blame. I, too, in my earlier days, have fallen by the way. Indeed, it was once facetiously said that the street in front of my office was paved with the turbinated bones of my victims.

That there are a host of conditions that call for more or less complete destruction of the tonsil is an axiomatic proposition which is not open to discussion. We have all been taking out tonsils for innumerable reasons ever since we entered our special field of work, and we will continue to do so when proper occasion demands it. My contention is simply this, that in selecting our cases for operation we should be guided by a sane and safe conservatism and common sense, and not be carried away by those who, by their precept and example, are fast bringing our specialty into disrepute in the eyes of thoughtful and honorable men.

Many years ago Austin Flint was conducting an examination in physiology at the Bellevue Hospital Medical School in New York. Among the students who came up for graduation was a bright young fellow to whom Flint propounded the following conundrum: "What is the function of the spleen?" And the lad replied that the function of the spleen was to enlarge in malarial fever. To the next question, "What is the function of the tonsil?" the boy declared that the mission of the tonsil was to swell and suppurate in quinsy. "That will do," said Flint, "you have passed a perfect examination, for you know as much about the subject as I do myself." Long before, a distinguished medical luminary on the other side of the Atlantic had said that were he, like Frankenstein, to attempt the artificial construction of a man, he would leave the tonsils out. In other words, at that period, or, as a matter of fact, from a period as long back as memory can run, the tonsil was regarded as a perfectly useless appendage which cumbered the throat, and which, therefore, ought to be gotten rid of. Like its little neighbor, the uvula, it was sacrificed on every possible pretext or when the surgeon did not know what else to do. I remember, a long time ago, in a discussion on hemorrhage after tonsillotomy before a New York society, a distinguished laryngologist made the statement that he had removed without accident many thousands (I have forgotten the exact number) of tonsils—to which declaration an inquisitive, incredulous individual present, with a mathematical turn of mind, said he had made a calculation which showed that in order to have removed that many tonsils within the limit of an ordinary lifetime the operator would have to average a bushel a day.

This general extirpation of the tonsils that obtained in the

early days of laryngology received a rude and jarring jolt when, in the last century, it was proclaimed that the tonsil was physiologically directly related to the virility of the male. According to this luminous conception, which owed its popularity chiefly to the teachings of no less a personage than Chassaignac, destruction or extirpation of the tonsil meant impairment or extinction of procreative power. This doctrine at once made tonsillotomy very unpopular among the male laity; but when the Homeric shock of the battle that raged around this burning question had subsided, and it had been found that there were no facts to support the alleged relationship, then the work of slaughtering the tonsils again went merrily on.

But never in the history of medicine has the lust for operation on the tonsils been as passionate as it is at the present time. It is not simply the surgical thirst from which we have all suffered in our earlier days, just as at a still earlier period we suffered from the measles; it is a mania, a madness, an obsession. It has infected not only the general profession, but also the laity. A leading laryngologist in one of our largest cities came to me with the humiliating confession that, although holding views hostile to its performance, he had been forced to do a tonsillectomy in every case in order to satisfy the popular craze and to save his practice from destruction.

Today the laity, with or without medical advice, insist on entire removal of the tonsil for almost every conceivable infirmity. If I had time to do so, I could tell you some, if they were not so serious, amusing stories in this connection.

I will only relate one. A few days ago a woman brought her little six-year-old daughter to me to know whether her tonsils ought to come out. Her nasal and throat passages were normal.

The child was in perfect physical condition and complained of nothing. I said to the mother: "Your baby is perfectly well; why do you want her tonsils out?" "Because she sometimes wets the bed."

In the annual reports of nearly all the special hospitals for diseases of the nose and throat the number of tonsil removals, as compared with all other operations on the upper air tract and its appendages, is simply appalling. In conspicuous and refreshing contrast to the usual narrative of these productions let me quote from the last report of a well-known children's hospital in this city these words of sanity and wisdom:

"A large and annually increasing number of cases apply for operation for hypertrophied tonsils, or for adenoids. Of these the adenoids practically all need and receive operation with benefit and without injury.

"The recent universal inspection of the throats of school children has revealed the fact that nearly all children at some time of life have more or less enlarged tonsils.

"That most of this is harmless if not actually physiological.

and that their removal in these cases is not only unnecessary but injurious to the proper development of the child is our conviction.

"The rarity of rheumatism or endocarditis in children, while nearly every child has enlarged tonsils, would indicate that their removal is only exceptionally advisable unless they mechanically interfere with respiration, deglutition, or speech. When this is the case they are still best removed with the tonsillotome unless radical extirpation is necessary for other reasons."

I cannot more correctly express the general attitude on the matter than by quoting the words of Professor Swain of Yale University, in the admirable paper with which he opened the debate on the subject at the last meeting of the American Laryngological Association in Philadelphia:*

"When an author speaks of his experience in upwards of 9000 cases, mentioning especially 3000 removed within the capsule within the last six or seven years, the only method which he thinks is really worth the while—he certainly has a right to speak as an expert in regard, at least, to methods. Also, it will be readily deduced that he felt in removing tonsils thus wholly he was not depriving the patients of anything important. When it is the practice in recent years of many operators all over the country to always enucleate the tonsils as completely as possible in all cases, either children or adults, as a routine procedure, it would certainly seem to argue that in general tonsils are better out than in. The question of relative size, appearance, healthiness of structure or any such matter is apparently never thought of. Remove, anyway, and dismiss the matter as not worthy of further consideration. And, again, it is a most excellent condition of things to be operating laryngologist to a busy internist, who takes the entire responsibility of removal. Failure and success are alike credited against him, but it is a case of blissful inexactness which I consider deplorable."

Much wild and incontinent talk, for which their teachers are sometimes largely to blame, has poisoned the minds of the younger generation of operators and thrown the public into hysteria. Tonsillectomy, for example, is held out to them, not only as a sure cure for, but as an absolute prophylactic against rheumatism and heart disease. They are told that with the disappearance of the tonsil in man, these diseases will cease to exist. Parents bring nowadays their perfectly sound children to the laryngologist for tonsil removal in order to head off these affections. Tonsillectomy is recommended as a curative during the agony of acute articular rheumatism.

But the origin of the latter disease has recently been traced to an infection of the nasal mucosa following operation. Tomorrow it will come from somewhere else. Those of us who are old enough to remember will recall the story of chorea. Years ago we found the cause of this affection in the nasal passages. When

*See Transactions, 1911.

this view, after the usual struggle, had to be abandoned, it was suddenly discovered that the eye was the portal of entrance. To-day it has been caught in the tonsil. If we exercise a little patience it will turn up soon in some other organ.

In considering the question of operation on the tonsil, and especially complete removal, we must face the following facts:

I. The functions of the tonsil are, in the present state of our knowledge, unknown.

Whether they are portals of entrance or avenues of exit for infection, whether they protect the organism from danger or invite the presence of disease, whether the pathogenic bacteria sometimes found in them are coming out or going in, whether they are manufacturers or storehouses of leuco—or lymphocytes, whether they represent the extreme outlying protective ramparts and that, therefore, their destruction would mean the removal of the battle-line against infection from the throat to the neck lymphatics, whether the efferent current of lymph exceeds the afferent in volume or velocity, whether, which seems probable, there is an endless flow of lymph from their interior to the free surface, which, unchecked, prevents the entrance of germs from the surface and washes out impurities from within, whether the organ possesses an internal secretion, *sui generis*, or whether, in fine, the tonsil structure is in any way essential to the well-being of the individual, are questions which have as yet received no definite solution, but which are full of interest and furnish material for instructive discussion and debate. Until the functions of the tonsil are known the final word on its removal cannot be spoken.

II. Whatever its functions may be, and the production of leucocytes is undoubtedly one of them, the tonsil is not, as is generally taught and believed, a lymphatic gland.

The general ignorance of this fact has led to the useless sacrifice of thousands of tonsils, on the fallacious assumption that their functional activity may easily be replaced by the myriads of other lymphatic glands in the body. The physiological integrity of the tonsil is of the utmost importance in infant and child life. The gland appears early in embryonic life (fourth month), attains maturity at the end of the first year of infancy, and at or about puberty tends to diminish in size. It does not develop as a lymphatic gland from a plexus of pre-existing lymph vessels in the mesothelium, but as an ingrowth of endothelium from the second branchial pouch and, therefore, in its origin must be classed with the thymus and the thyroid, the former originating from the third, the latter from the fourth, while the parathyroid takes its origin from the third and fourth branchial pouches, all by inbudding of the endothelial lining of the primitive pharynx. These anatomical facts have been recently emphasized by Gordon Wilson* of Chicago, who, in a careful study in comparative anatomy, has shown from various relations which the tonsil shows to the

*Transactions of the American Laryngological Association, 1911, p. 263.

pharynx that the tonsil secretes or excretes a substance into the pharynx. The tonsil is present in all mammals, with a few exceptions, notably the white rat, and its anatomical arrangement is such that no matter how concealed it may be by folds of membrane it always retains communication with the pharynx. Observations made in his laboratory on the carnivora show that in this genus the tonsil is often so protected by folds as to be invisible from the mouth; but there always exists a channel of communication. This is well shown in the lion, where the tonsil lies in an elliptical sac of considerable size, which is so placed that during certain movements of the pharynx the contents may be expelled into the back of the mouth. In other words, we have here a structure which plays a rôle of importance in early life, in addition to its production of lymphocytes, and which necessitates a close relation to the pharynx. This rôle may be of infinite value to the infant in his earliest days of life, but which, as he grows through childhood into manhood, he is able to dispense with.

Now, the first organ to manufacture or store leucocytes in embryonic life is the thymus gland (Jacobi).† In view of the origin of the tonsil from the branchial pouch, is it not conceivable, as Jacobi suggests, that it may assume the rôle of the thymus after birth or when the latter gland ceases to functionate or disappears?

III. It is rarely possible to separate the tonsil from its neighborhood during the acute invasion or rapid progress of a microbic or toxic poison (Jacobi).

Years ago Jacobi called attention to the fact that in cases of membranous throat disease, whenever the membrane is limited to the tonsil, there is little or no glandular swelling in the neighborhood. If the membrane extends from the tonsil to its neighborhood, or starts at a distance from the tonsil, neighboring lymphatics swell at once.

Again, the treatment of this neighborhood shows its effect almost immediately in the swollen glands. This is especially true of diphtheria, which, when limited to the tonsil, produces less adenitis and constitutional symptoms, and, therefore, is less dangerous. We all remember, too, in the days before antitoxin, how much graver the prognosis was when the membrane appeared in the nose and upper pharynx than when it appeared on the tonsils. Nearly every case died.

IV. The rôle of the tonsils as portals of infection, like all new doctrines in medicine, has been greatly exaggerated. To state that they are, in certain cases, the avenues through which pathogenic organisms reach other organs is simply to state an incontrovertible proposition, in the light of present-day research. But to make them responsible for the long Iliad of woes which has been laid to their account is to remove the whole question from its legitimate place in the region of cold clinical fact into the atmosphere of

†*Archives of Pediatrics*, July, 1906.

fads and fancies. Some absorption takes place in and from the tonsil, but it is far less than that which occurs in the more abundant and receptive lymphatic structures of the nose and nasal pharynx. The tonsil, moreover, is not built anatomically as a gateway of infection. I have not time to go into a review of this interesting subject, but will simply quote, with some modification, from a summary by Faulkner of Pittsburgh (*Medical Record*, July 9, 1910), based on an analysis of observations made by Most, Retterer, Labbé, Hodenpyl, Jacobi, Grober and others, and also refer you to a symposium on the subject of the naso-pharyngeal lymphatics and their relation to other parts of the body by Hartz, Poli, Logan Turner and Broeckart:*

"The faucial tonsils are peculiar organs. They possess an anatomical character different from other tonsils and other lymphatic tissues. They are innocent organs with functions chiefly confused by medical literature. Their blood supply is scant and they have almost no communication with the lymphatic system. * * * Their crypts are lined by mucous membranes having the ordinary function of other mucous membranes so far as known. They are distinctly separated from the very active absorptive and bacteriolytic structures of the fauces, pharynx and nose. Their position is a segregated one. Their external deep surface is covered by a dense fibrous capsule which sometimes sends a network of fibrous tissue as outrunners along the tonsillar blood vessels (Hodenpyl), the tonsil contains a system of closed lymph canals in the follicles which do not open into the connective tissue reticulum (Retterer, confirmed by Hodenpyl), diphtheritic membrane confined to the tonsil is relatively innocent (Jacobi). There are no lymphatic sinuses around the tonsil, and the nearby lymph current is less active than that of the pharynx at some distance (Labbé), and, finally, injections made into the region of the tonsil (not even into the tonsil itself) do not spread like those made into other parts of the naso-pharynx (Labbé, Retterer, Hodenpyl, Most and Jacobi)."

Hartz,† in reviewing the important experiments of Lenhardt, says: "These experiments would lead to the assumption that the tonsils are frequently infected secondarily to acute infection of the nose and the accessory cavities and the nasopharynx. * * * It is probable that every inflammation of the mucosa induces a swelling, often imperceptible, of the neighboring lymphatic glands of greater or less extent, which, acting as a protective mechanism, inhibits the development of the germ. To the tonsils, which have the function of an open lymphatic gland, may be ascribed a protecting influence against the micro-organisms which are ever present in the mouth and nasopharynx, acting, also, as a barrier against their invasion into the trachea and esophagus. On the other hand, it must be admitted that the tonsils

*These papers have been collected, the foreign ones translated into English, and published in the *Laryngoscope*, March, 1912.

†*Laryngoscope*, March, 1912, p. 180.

are frequently the seat of primary inflammation, and that they are more susceptible to disease than other membranous structures in this region."

The question has two sides—a purely bacteriological and a purely clinical one. If we consider the vast extent of the area through which infection can possibly take place, and if we follow the lead of experiment and that of the pure bacteriologist to its extreme limit and logical end, we may find that nothing short of the guillotine or the axe will insure the patient against absolute and certain immunity from infection through the throat.

On the other hand, when we consider the fact that there are constantly loitering around the oro and nasal pharynx—this region is the clubhouse of the streptococcus—a miscellaneous crowd of pathogenic bacteria, and when we consider the further fact that thousands of operations are done in these regions every day, and necessarily without antiseptic precautions, is it not significant at least that we meet with so little sepsis following their performance?

V. The chief practical lesson to be drawn from the foregoing facts is that in cases in which the throat, and particularly the tonsils, is apparently the starting point of infection, it is mandatory to examine the entire upper air tract and not be content with appearances that are visible to the eye through the open mouth alone. How many stop their search for the cause at the tonsil and fail to explore the deeper parts of the pharynx, the retro-nasal space, to say nothing of the nasal passages and accessory sinuses? This entire region must be reckoned with, and failure to do so has probably sent more than one to his grave. I know of a number of cases of fruitless removal of the tonsil which have only gotten relief when treatment was subsequently directed to the nasal cavities and post-nasal space. Not to mention many others, I am forcibly reminded of a case of general poisoning and wrecked health in a young woman in whom I had thought I had traced the source of infection to an antrum maxillae empyema. As there was no escaping pus, my diagnosis was not accepted by the family and attendant, and I was not even permitted to make an exploratory puncture. I am unable to say what operation, if any, was done, as she naturally passed out of my hands. But as she grew rapidly worse, and as the futility of the treatment became apparent, my advice was finally reluctantly and doubtfully taken, the antrum was opened, the fetid contents evacuated, and the patient, under appropriate treatment, went on to speedy and complete recovery.

I could tell you, also, of cases in which the tonsil has been held responsible for the morbid condition, and has been partially or completely removed, in which relief has only been secured by the discovery and treatment of disease in the nose and retro-nasal space. And of far graver, far-reaching and deeper significance are cases of infection in which life has doubtlessly been

sacrificed by clinging to the lazy and stupefying delusion that the tonsil is the sole portal of poisoning.

VI. The hypertrophied lymphatic tissue of the vault of the pharynx (adenoids) does harm chiefly through obstruction. Restore normal respiration in the child, and in a large number of cases the tonsils will take care of themselves. Even if the glands should remain large, if they are giving no trouble, they may be safely left *in situ*, for as their growth does not go on *pari passu* with the growth of the rest of the pharynx, the time soon comes when they become inconspicuous in the fully developed fauces.

The mere size of the tonsil is of itself no indication for removal except it be large enough or diseased sufficiently to interfere with respiration, speech or deglutition, in which case it, or a sufficient portion, should be taken away without delay. A large tonsil does not mean necessarily a diseased tonsil, nor does a small tonsil always indicate a healthy organ. Tonsils apparently diseased may consist of normal tissue, and, on the other hand, perfectly normal-looking glands may be found pathological microscopically. The tonsil may be greatly enlarged, may extend far down into the pharynx or be buried deeply in the palatine arcade, and yet not interfere with the well-being of the individual. Such tonsils are the special prey of the tonsillectomist. If they are not interrupting function, they had best be left alone, for they are doing no harm. The change in anatomical relations after operation is often so great that function is crippled more after their complete removal than it was before. Moreover, it occasionally happens that the resurrection of a "buried" tonsil is followed by the burial of the patient.

A most interesting and instructive part of this subject is the occurrence of tonsil disease, with or without cervical adenitis, from infection from the nasal passages (from pus cavities, operations, etc.) and the improper care of the teeth during dentition. Wright* of Boston reports a remarkable series of 150 cases in which operation on the tonsils was deferred until after the eruption of the molars, not only in the six, but in the twelve-year period, and when dentition had been completely accomplished the enlarged cervical lymphatic glands disappeared, together with the swelling of the tonsils.

Tonsillitis not infrequently follows operations on the nasal cavities, especially if pus be present, or even after a cold in the head. Experimental work along this line would seem to indicate that infection takes place through the lymphatics. Thus, in the carefully conducted experiments of Lenhardt† it was found, among other things, that foreign matter, even when injected into the mucous membranes of one nasal passage, was found in both tonsils a short time after the injection.

The practical illuminating lesson of these observations is that

**Boston Medical and Surgical Journal*, May 20, 1900.

†*Archiv f. Laryngologie*, 1909, Bd. XXI.

if, in infancy and childhood, we pay more attention to the neglected nasal cavities and to the hygiene of the mouth and teeth, we will have less tonsil disease and fewer tonsil operations.

VII. In the permanent removal of tonsil disease equally good, and in the long run even better results may be obtained in a large percentage of cases by measures less radical than those usually employed at the present time. Out of a multitude of examples, take the case of recurring quinsy, for which complete enucleation is done. In this condition it has been found that it is frequently only necessary to thoroughly slit up and shrink the upper lobe of the tonsil. Most quinsies occur in this situation, and the destruction of that part of the tonsil is all sufficient to prevent recurrence. By this method enough of the organ is left to entirely perform its function, and the ultimate development of quinsy of the lateral columns of the pharynx which follows sometimes complete removal is avoided.

VIII. I do not propose to enter the perennial and monotonous controversy of tonsillotomy versus tonsillectomy. Each operation has its legitimate indications and aims. I do not intend to discuss them. I will only say, in passing, that enucleation of the tonsil, with even the removal of its capsule, if so desired, complete enough for all practical purposes, and this fact should be generally known, practically free from danger and with equally, and in some instances better results, can be done with the guillotine or one of its modifications. In the majority of cases this procedure will be all sufficient. It is a much simpler method, especially in children, and it is not handicapped by the danger of complete enucleation, with its many accidents and complications, to say nothing of its long roll of unrecorded deaths. To subject a child to the latter operation, with all that it entails, when we have very much safer and practically just as efficient measures at hand, is, to say the least, bad judgment and unnecessary surgery.

As I see this part of the subject in the light of my own experience, and in the experience and observation of others, the truth is slowly but surely dawning, and at no distant day will irresistibly emerge into recognition that the so-called complete enucleation—the chief objection to which is that it can never be made complete—except in individuals in whom the organ is totally diseased, is an unnecessary operation in the great majority of cases in which it is at present done, and may be supplanted by many other methods which are perfectly safe and efficient and not open to its many serious objections. That the tonsil has some important mission to fulfil is furthermore shown from its frequent reappearance after enucleation—a protest, as it were, on the part of nature against the total destruction of its functions, and the vicarious activity of the neighboring lymphatic tissues when its

physiological properties cease to exist. This is strikingly shown in the case of quinsy of the lateral columns of the pharynx, before referred to, when the tonsil is rudimentary or gone. In the case, too, of infectious disease whose poison is eliminated by the throat this compensatory action is most marked. Thus in the malignant epidemic of tonsillitis which occurred last year in Boston, in which the disease was not contagious, did not start from a septic focus in the throat, but was introduced through the food supply (milk), after much constitutional disturbance, the whole tonsillar ring, as Coolidge* expresses it, broke into flame at once. The patients whose tonsils had been removed did not escape the process in the pharyngeal lymphoid tissue, the constitutional symptoms or the cervical adenitis.

IX. The tonsils are phonatory organs and play an important part in the mechanism of speech and song. They influence the action of the surrounding muscles and modify the resonance of the mouth. On the other hand, they may be so enlarged as to cripple both these functions, and should, therefore, be removed, such removal being sometimes a gain to the voice of one or more octaves. In tonsillectomy no one can foretell the amount and character of change in the anatomical relations of the parts, no matter how skilful the surgeon is or how skilfully the operation is performed. The adhesions and contractions left after this operation, even in the best of hands, lead often to deplorable changes in the quality and ruin of the singing voice. I should certainly hesitate long before advising such an operation in a great singer or anyone dependent upon the voice as a means of livelihood. The operation of tonsillectomy is a capital operation, a dangerous operation, and should only be done in a hospital or other place where every facility is at hand to meet the gravest possible emergency. It should only be done by a surgeon skilled in its performance and thoroughly equipped for every accident, and with a mind fully awake to the possible fatality which has so often followed as its result.

X. One word, again, to those who will fail to grasp the meaning of these remarks. It is not my object to decry in the least degree the many excellent measures which modern ingenuity has devised for the surgical treatment of tonsil affections. No one resorts to them with more alacrity than myself when the necessity for their adoption is apparent.

It is not my purpose to assail operation for definite and legitimate cause, but to warn against the "busy internist," as Swain so aptly terms him, who is too busy to waste his time with such trifles as differential diagnosis or diagnosis by exclusion, and his accommodating tonsillectomist, who, whether he admits it to him-

*Transactions American Laryngological Association, 1911, p. 272.

self or not, cares less about the cause of the trouble, as he is in the business for revenue only.

We who are teachers of laryngology should wake up to the responsibilities of our position and see to it that our pupils shall not leave our institutions or post-graduate schools until they are taught, on the one hand, conservatism and moderation in the surgical treatment of the simpler affections of the upper air tract, and, on the other hand, thoroughness and completeness when brought into the presence of situations of graver emergency. The problem, though difficult, is not impossible of solution. The cure for the evils I have been discussing is largely educational. While impressing upon our students the absolute necessity for surgical measures in proper cases, we should at the same time make the dangers of their indiscriminate performance fully apparent. In this way only can we be reasonably sure of accomplishing the desired result. The error of first impression derived from teacher and textbook is often difficult of eradication. In the lecture-room, in the clinic, in our daily walks with the student, let us make that first impression a good one.

But equally, if not more, responsible for the deplorable state of affairs which exists today in the matter under discussion are the teacher of internal medicine and the general surgeon. When pre-eminent authority proclaims in lecture-room and textbook as indisputable truth the relationship between a host of diseases and the tonsil of the child, and advises the removal of the glands as a routine method of procedure, what can we expect of the student whose mind is thus poisoned at the very fountainhead of his medical education by ephemeral theory that masquerades so cheerily in the garb of indestructible fact? How are we to offset the irresponsibility of the responsible? But we hear on all sides, "Look at the results." Results? Here is a partial list from the practice, not of the ignorant, but of the most experienced and skilled: Death from hemorrhage and shock, development of latent tuberculosis in lungs and adjacent glands, laceration and other serious injuries of the palate and pharyngeal muscles, great contraction of the parts, removal of one barrier of infection, severe infection of the wound, septicemia, troublesome cicatrices, suppurative otitis media and other ear affections, troubles of vision and voice, ruin of the singing voice, emphysema, septic infarct, pneumonia, increased susceptibility to throat disease at the seat of operation, pharyngeal quinsy, and last, but not least, tonsillitis!

Who, may I ask, is in the better position to advise, the surgeon or practitioner, who, without sufficient knowledge, lightly recommends complete enucleation of the tonsils, or those who have devoted their lives to the study of throat conditions and who come in daily contact with its disastrous and often fatal end results? Formerly it was the nasal septum, now it is the tonsil that is the surgical objective of every beginner in laryngology, and a tonsillectomy is usually his first baptism of blood. This operation

is done all over the land by operators of all kinds, and, if the truth were known, with great mortality. The amount of reckless surgery done in this field will never be known or chronicled in the pages of medical literature, but it may be found in its abiding place in the book of the recording angel.

Let us hope that the day is not far distant when not only the profession, but the public shall demand that this senseless slaughter be stopped. Is not this day of medical moral preaching and uplifting a fitting one to lift the public out of the atmosphere in which it has been drugged, and for the reckless tonsillec-tomist a proper time to apply the remedy of the referendum and recall?

We are going through today in laryngology what the gynecologist went through years ago. The ovaries were removed then under as little provocation as the tonsils are being taken out today. The so-called "tonsil question" is one of simplicity and comparatively small dimensions when viewed in the light of sanity and common sense, but it has been made to assume formidable proportions by unsound observation and reckless surgery. It has come to a point when it is not only a burning question to the profession, but also to the public. This senseless, ruthless destruction of the tonsil is often so far-reaching and enduring in its evil results that it is becoming each day a greater menace to the public good. Until we have more definite knowledge concerning the use of the tonsils no one can tell the damage done to the children of the present generation or the influence of wholesale tonsil removal on the children of the next. Whatever a more exact examination of the tonsil may reveal as to its function, I believe it was placed in the throat not with evil, but with good intent; to serve a teleological rather than a pathological purpose; that its mission is physiological, and that it was not designed by Nature as a natural, easy and convenient avenue of infection. It is, of course, not open to debate that there are a multitude of conditions that call for partial destruction or more or less complete removal of the tonsils, but radical operation should not be done without definite and sufficient reason. The tonsil should not be sacrificed any more than any other organ without convincing evidence that it is the cause of the disease to be removed.

Hasty theory, which sees in destruction of the tonsil the only means of treatment, and which, unmindful of the lymphatic and other anatomical arrangement of the neighboring structures and their physiology, and which, losing sight of the further fact that it is hard, if not impossible, to determine during life that the tonsil is the only avenue of entrance in a given infection, throws differential diagnosis to the winds, should have no part in modern scientific laryngology. When we shall clarify the atmosphere of our ideas in this matter, and when sane authority shall demand a halt, then we will hear less of the massacre of innocent organs and have less frenzied literature on the subject.

TYPHOID FEVER AND THE WAY TO PREVENT IT.

By C. W. G. Rohrer, M.D.,

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(Continued from August Issue.)

V. CONCLUDING REMARKS.

Those who have followed the thread of my discourse must now be cognizant of the fact that typhoid fever is one of the most fatal diseases in Maryland. On an average, 1 case in 15 results in death.¹³ It is a communicable disease, because it is only contracted by passing from one patient to another. Animals do not get it, but animals may convey the perilous germs from place to place. This, I believe, occurs with greater frequency than is ordinarily supposed.

I trust the picture which I have painted tonight has been duly impressed upon your memories. It is not an exaggeration—not an overdrawn one. The disease is peculiar, because it strikes right at the fountain-head of the race. True enough, helpless infancy and tottering old age are not altogether exempt; yet nine-tenths of the cases occur in persons in the prime of life. Contrary to the disease tuberculosis, typhoid fever more generally attacks males. But neither sex nor age, station or status in life, is a ban against the onslaught of typhoid fever. It has bowed the head of sturdy manhood into the dust; it has filled with anguish the heart of the young woman, so cruelly bereft of the protecting arm of her husband. It has caused these two—the young husband and the young wife—to stand by the open grave with uncovered head and tear-dimmed eye, because typhoid fever, like Herod of old, has slain their first-born.

Nor is this all. A portion of those who recover from the immediate attack bear the scars of the fierce battle to the end of their days. Complications and after-effects, almost without number, are liable to result.

There is still another grave danger attached to an apparently recovered typhoid fever patient. It is the possibility of such a one becoming a typhoid carrier. In such cases the typhoid bacilli find permanent lodgment in the intestinal canal or in the gall-bladder, to be excreted in the stool even years after the primary attack. There is apparently no limit to the duration of the danger period in a chronic typhoid carrier. In Massachusetts there is a case on record where a good old lady transmitted the disease in this manner to her grandchild. In Maryland we have had one instance wherein a total of 22 cases were caused by a bacillus carrier. One of the 22, the carrier's own son, resulted fatally. If washing the hands with soap and warm water were more fashionable among typhoid bacillus carriers, such unfortunate results could not occur.

¹³The proportion is even greater here in rural Maryland, being, I should say, about one in ten.

It was the late eminent Louis Pasteur¹⁴ who said: "It is within the power of man to rid himself of every parasitic disease." The late Dr. Nicholas Senn¹⁵ of Chicago stated that even tuberculosis will be wiped from the face of the earth by the end of 25 years. These statements, coming as they do from such world-wide authorities, should inspire us with hope. They should enable us to buckle on our armor with renewed courage and wage a more determined warfare against the introduction and spread of typhoid fever.

The Frostburg public water supply is above reproach. Coming as it does from distant and cooling mountain springs, remote from the habitation of man, it is one of the purest and best drinking waters in the State. For this reason, I do not see why a single surface well should be used in Frostburg. We usually classify wells as follows:

1. Surface Wells—Shallow (8 to 25 feet deep), and absolutely unsafe. A menace to the health of those who use the water drawn from it.

2. Dug Wells—From 30 to 60 feet deep. Safer than the foregoing, but still liable to surface pollutions and contamination of the water-bearing strata.

3. Driven Wells—From 100 to 150 feet deep; even deeper. Usually found to be a fairly safe source of drinking-water supply. The town of Ridgely, Caroline county, might be cited as an example where driven wells are in general use.

4. Artesian Well Supply—The banner class. Usually bored many feet through rock, etc., it furnishes an ideal water supply—pure, cool, wholesome—and contamination is exceptionally rare.

The mountain spring has a record equally as good as the artesian well. The "spring 'neath the old gum-tree"¹⁶ usually has a somewhat checkered career, owing to its liability to contamination by surface water.

In regard to the milk supply, go to the dairy farm and inspect it, and see that it is absolutely clear of persons having typhoid fever. It would be a criminal act for a dairyman to sell milk if he suspected it to be conveying typhoid fever. Allow no typhoid fever patient, or recovered patient, to come within a mile of the dairy farm until his bowel and bladder discharges have been demonstrated to be free from typhoid germs.

Watch over those from whom you purchase your raw foods.

¹⁴Louis Pasteur, born December 27, 1822; died September 28, 1895. A celebrated French chemist and microscopist, noted for his studies on fermentation and his researches in the then new science of bacteriology. We are also indebted to him for the prevention of hydrophobia by inoculation, or, in common parlance, the Pasteur treatment.

¹⁵Born October 31, 1844; died January 2, 1908. A leading American surgeon, surgical bacteriologist and surgical pathologist.

¹⁶The first stanza of this well-known pastoral poem comes very vividly to my mind. It is as follows:

"There's many a spot on the old home place
That I'm wishing and longing to see;
But the dearest of all is the meadow lot
And the spring 'neath the old gum tree."

such as lettuce, cabbage, spinach, etc. Also be careful not to wash such products with infected water; use boiled water if there is any suspicion of typhoid. Even raw oysters, fattened in polluted water or collected from sewage-contaminated oyster beds, have been known to convey typhoid fever, as the inhabitants of Woodstock, Baltimore county; Catonsville, Baltimore county, and Elkton, Cecil county, can bear unfortunate testimony.¹⁷

Catch and kill the flies. The statement, "Swat the fly," has become obsolete. Catch it and kill it.¹⁸ Make your town clean, so that, like Noah's dove, the fly cannot find a resting place or a breeding place.

Open drains should be covered; open sewers walled in. Garbage and other refuse should be collected at regular intervals. Your efforts of last Wednesday are very commendable, and I desire to publicly praise you for them. But I would like to suggest that you continue your good work throughout the year.

The people of Frostburg are to be congratulated upon the public health movement which they have inaugurated and for the laudable example which they have set. In the battle of life, health has no handicap. It is true, the race is not always to the swift, nor the battle to the strong; but a man or a woman who enjoys the greatest of all blessings, namely, good health, possesses numerous advantages over the lame and the halt and those otherwise incapacitated by disease.

I am glad that the town of Frostburg, beautifully situated and delightfully envired, is letting her light shine instead of hiding it under a bushel. I sincerely trust that other cities and towns, seeing your good works, will copy your wholesome example.

In conclusion, I desire to thank the Board of Health of Frostburg and the Civic League for their kind invitation to be present tonight and address this meeting. I know that Frostburg will soon be the cleanest, healthiest and happiest town in the State of Maryland, because the women folks are taking such a prominent part in the work of civic betterment. I am one who believes that noth-

¹⁷In November, 1910, there occurred in Woodstock, Baltimore county, Maryland, an outbreak of typhoid fever attributed to eating raw oysters. There were five cases of sickness. In January and February, 1912, a similar outbreak occurred in Catonsville, Baltimore county, and also in Elkton, Cecil county. In the former there were ten cases of the disease; in the latter six cases.

¹⁸To show how our attitude towards the fly has changed, I wish to quote the following poem, written by Vincent Bourne, an usher in Westminster School, born about 1695, died December 2, 1747:

"THE FLY.

"Occasioned by a Fly Drinking Out of the Author's Cup.

"Busy, curious, thirsty fly!
Drink with me, and drink as I!
Freely welcome to my cup,
Could'st thou sip and slip it up:
Make the most of life you may:
Life is short and wears away!

"Both alike, both mine and thine,
Hasten quick to their decline!
Thine's a summer; mine no more.
Though repeated to threescore!
Threescore summers, when they're gone,
Will appear as short as one!"

ing of real value is accomplished without the sympathy and support of the feminine part of the population. To substantiate my position, I desire to quote a stanza or two from the works of the late Miss Kate Field,¹⁹ a brilliant Washington woman who left the world brighter and better for her having lived in it. Miss Field wrote:

"They talk about a woman's sphere as though it had a limit;
There's not a place in earth or heaven,
There's not a task to mankind given,
There's not a blessing or a woe,
There's not a whispered yes or no,
There's not a life, or death, or birth,
That has a feather's weight of worth—
Without a woman in it."

¹⁹Mary Katherine Keemle Field, American author and lecturer, born October 1, 1838; died May 19, 1896. She founded a weekly review, called "Kate Field's Washington," whose initial number was issued on January 1, 1890. She was the first American woman of note who left instructions in her will for the cremation of her body after death.

Book Reviews.

A COLLECTION OF PAPERS PUBLISHED PREVIOUS TO 1909. By William J. Mayo and Charles H. Mayo. Two octavo volumes, averaging 550 pages each. Illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Per set, cloth, \$10 net. 1912.

The influence of the Mayo brothers upon American surgical methods has been so extraordinary—perhaps it would be better to speak of it as revolutionary—that the surgeons of the country are always eager for any contribution from their pens. Of necessity many of the propositions set forth in their earlier papers have been changed by time and a more mature experience. Yet, in order to round out their work and to give the profession the benefits of their earlier contributions, the Saunders Publishing Co. has brought together in two volumes the most important of the papers published in the various journals of the country of these two men. Though the Drs. Mayo are best known for their work on the thyroid gland and abdominal surgery, a thorough inspection of the above volumes will attest to their versatility as general surgeons of the highest rank. A feature of the papers comprising the present books as well as all writings by the brothers is their brevity. They are pastmasters at saying what they have to within the shortest compass of space, and when they have finished about all that is known on the subject has been said. Here, as in their other writings, the methods pursued at their clinic is told in precise and concise language. As in the volumes of papers written after 1909, so in these the papers are arranged under the various systems, to wit: alimentary canal, stomach,

liver and gall-bladder, pancreas, intestine (general), intestine (tuberculosis), colostomy, intestine (cecum), sigmoid and rectum, hernia, genito-urinary organs, skin, vascular system, head, central nervous system, neck, thyroid, goitre, bones and joints, principles of surgery, travelogue and addresses.

THE PITUITARY BODY AND ITS DISORDERS. Clinical States Produced by Disorders of the Hypophysis Cerebri. By Harvey Cushing, M.D., Associate Professor of Surgery, Johns Hopkins University; Professor of Surgery (Elect), Harvard University. An Amplification of the Harvey Lecture for December, 1910. 319 illustrations. Philadelphia and London: J. B. Lippincott Company. Cloth, \$4 net. 1912.

The above book was deemed sufficiently meritorious to demand an editorial; therefore, it is reviewed by title.

SURGICAL AFTER-TREATMENT. A Manual of the Conduct of Surgical Convalescence. By L. R. G. Crandon, A.M., M.D., Assistant in Surgery at Harvard Medical School; Assistant Visiting Surgeon to the Boston City Hospital; Consulting Surgeon to Frost General Hospital and to Woonsocket Hospital, and Albert Ehrenfried, A.B., M.D., Assistant in Anatomy at Harvard Medical School; Surgeon to Mt. Sinai Hospital; Surgeon to Boston Consumptives Hospital, etc. Second edition, practically rewritten and thoroughly revised. With 265 original illustrations. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Octavo of 831 pages. Cloth, \$6 net; half Morocco, \$7.50 net. 1912.

If our readers recollect at the time of the appearance of the first edition of Crandon's "Surgical After-Treatment," we predicted that it would be accorded a gratifying reception, as the field it covered was unique. Since its appearance surgical textbooks have continued to neglect the features of surgical treatment with which this book deals. And if one stops to consider that a very important part of any operation is a proper understanding of the post-operative treatment, otherwise a perfectly good operation may go for naught, then only can one appreciate the value of such a book as the above to raw medical internes as a guide to the correct handling of a given case after operation. During the past few years the post-operative technic has undergone many important changes. The author being aware that his book had to a large extent lost thereby its usefulness, he has, in conjunction with Dr. Ehrenfried, eliminated the obsolete features and added the newer methods, which have been proven practical and useful. In fact, the contents have been so radically changed that, rather than a second edition, the present is to all intents and purposes a new book, and should prove as helpful to internes and those not skilled in after-treatment as its predecessor.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE JUNE (1912) EXAMINATIONS.

ANATOMY.

1. What are the characteristics of the cervical vertebrae?
2. Describe the knee joint.
3. Origin, course and distribution of phrenic nerve?
4. Describe the prostate gland.
5. Give origin, course and termination of saphenous veins.
6. Of what does the sympathetic nervous system consist?
7. (a) What are the divisions of the brain? (b) Name the principal fissures. (c) What fissures divide each hemisphere into lobes? (d) Name the lobes of the brain. (e) Of what does the corpus callosum consist?
8. Gross anatomy of lungs?
9. Give origin, insertion and nerve supply of the following muscles: Brachialis anticus, infraspinatus, pectoralis minor, serratus magnus, piriformis.
10. Name visceral branches of abdominal aorta, or what arteries supply the thyroid body and from what larger vessels are they derived.

SURGERY.

1. Define proctoclysis. Describe its uses and mode of administration.
2. Describe Fowler's position and conditions adapted to its use.
3. Define gastro-enterostomy. Describe the operation and a case of a character requiring such a procedure.
4. Hemorrhoids. Describe them and an operation for their radical cure.
5. Mastoiditis. Cause and treatment.
6. Ophthalmia neonatorum. Causes and treatment.
7. Define hyperthyroidism: its diagnosis. Describe a case in your judgment requiring surgical treatment.
8. Colles' fracture. Describe and give its treatment.
9. Describe pes planus. Give its cause and treatment.
10. Define orchitis, osteitis, osteomyelitis.

PATHOLOGY.

1. Hookworm. Give scientific name, life history and method by which infection occurs.
2. Obstructive jaundice. How caused. Mention four lesions causing this symptom. What surgical significance has jaundice, and why?

3. Define atrophy, hyperplasia, complement, thrombus, infarction.

4. Mention three conditions, not obstructive, that cause dyspnea. Discuss one of the three named and explain fully why it causes dyspnea.

5. Describe the general method used to isolate and recognize bacteria.

6. Describe the appearance and condition of the bladder late in a case of prostatic hypertrophy of long standing.

7. Give the morbid anatomy of acute poliomyelitis.

8. What is the vaccine which is used to immunize against smallpox? How is it prepared? How does it act?

9. What are the distinguishing features of a malignant growth?

10. Give the morbid anatomy of emphysema.

OBSTETRICS.

1. Describe the ovaries and their structure.
2. What is puberty?
3. Describe the fetal heart sounds, their rate, when and where best heard.
4. Describe external pelvimetry.
5. What is ballotement?
6. How would you do a pubiotomy?
7. What treatment would you use in the pernicious vomiting of pregnancy?
8. How would you treat inertia uteri during labor?
9. Describe the operation for ventrifixation and suspension.
10. Give treatment of acute infectious diarrhea of infants.

PRACTICE OF MEDICINE.

1. Define: (a) Landry's paralysis; (b) pelagra; (c) nephro-lithiasis; (d) dysphagia, and name some diseases in which it occurs; (e) cretinism.
2. Define: (a) Percussion; (b) mensuration; (c) auscultation; (d) succussion; (e) palpation.
3. Give differential diagnosis between:
Membranous and spasmodic croup.
4. Renal and hepatic colic.
5. Peritonitis and enteritis.
6. Hysteria and epilepsy.
7. Give treatment of pertussis.
8. Give treatment of interstitial nephritis.
9. Give diagnosis and treatment of sero-fibrinous pleurisy.

10. Give cause, diagnosis and treatment of tetanus.

CHEMISTRY.

1. Explain the following terms: (a) Reaction; (b) nascent state; (c) molecular weight; (d) colloid; (e) valence, and give an example of each.

2. Describe in detail the chemical examination of a specimen of urine, giving the tests used and the results you would expect if urine was pathological.

3. Give one chemical antidote for each of the following: (a) Argenti nitras; (b) phenol; (c) zinci sulphas; (d) arseni trioxidum; (e) acidum sulphuricum.

4. Define: (a) Amphoter reaction; (b) ptomaines; (c) halogens; (d) specific gravity; (e) calorie.

5. Give the chemical formula of each of the following: (a) Ethyl alcohol; (b) methyl alcohol; (c) iodoform; (d) glycerine; (e) benzene.

6. (a) What are precipitins? (b) Lysins? (c) Agglutinins? (d) What is a toxin? (e) What is antitoxin?

7. What are normal and deci-normal volumetric solutions? How are they made?

8. (a) How would you show the presence of organic matter in water? (b) Name the chief constituents of milk? (c) Give the properties, chemical formula and uses of permanganate of potash?

9. Describe Marsh's test for arsenic.

10. Give a chemical classification of food-stuffs, with an example of each.

MATERIA MEDICA.

1. Mention six methods of administering drugs and give one example of each method.

2. Name some circumstances which may modify the effect of drugs.

3. Name three drugs which act as circulatory stimulants, and dose of each. Name three circulatory depressants.

4. Write a prescription for a three-ounce mixture containing syrup of ipecac, potassium citrate and syrup of wild cherry for a child two years old. One for an adult containing arsenic, strychnine, iron and quinine in pill form, using official names and endings.

5. Give official name and adult dose of calomel, Epsom salts, Hoffman's anodyne, Brown's mixture, paregoric, Fowler's solution and Donovan's solution.

6. Give official preparations of digitalis, with adult dose of each.

7. What is an anthelmintic? Name three drugs used as such.

8. What is the source of ichthyol, iodine, opium, ergot and camphor?

9. Give the average adult dose of potas-

sium iodide, compound jalap powder, extract camabis indica, fluid extract of ergot and morphia sulphate.

10. What is salicylic acid? How prepared and its salts?

THERAPEUTICS.

1. Write a prescription in Latin, without abbreviation, containing four ingredients which you would use for chronic bronchitis with abundant secretion, with direction for use.

2. Write a prescription in Latin, without abbreviation, containing four ingredients which you would use for an acute bronchitis, with directions for use.

3. Give five indications for and therapeutics of a venesection.

4. Define chemical incompatibility and physiological antagonism, and write two prescriptions in Latin, without abbreviation, illustrative, and explain the incompatibility and antagonism.

5. What are the therapeutic uses of opium? Describe symptoms of poisoning and treatment.

6. What are the therapeutic uses of strychnine? Describe symptoms of poisoning and treatment.

7. Describe means and methods of inducing local and general anesthesia, dangers and prevention.

8. Give the therapy of digitalis and contra-indications for its use.

9. Give the physiological action and therapeutics of santalin.

10. Give the physiological action and therapeutics of oleum ricini.

PHYSIOLOGY.

1. Describe the physiological changes in the uterine muscles during pregnancy and puerperium.

2. Define systolic, diastolic and mean arterial pressure.

3. Leucocytes: (a) Number normally; (b) some of the conditions affecting the number; (c) classification of the varieties.

4. (a) Describe blood plates. (b) Give three tests for blood.

5. Define eupnea, dyspnea, hyperpnea and apnea.

6. Urine; specific gravity; reaction; average quantity in 24 hours; quantity of urea in 24 hours.

7. Aphasia. Define the difference between sensory and motor.

8. State what is known of the thymus gland.

9. Name four glands having internal secretions and the effect of these secretions.

10. (a) Name the bile salts. (b) The bile pigments. (c) Give Pettenkofer's test for bile acid and Gmelin's test for bile pigment.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1912.

No.		Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Material Medica.	Therapeutics	Physiology	Total	Average
	COLLEGE OF GRADUATION.											
1	Georgetown Medical, '11	69	..	75	..	..	..	64	67	..	...	..
2	Medico-Chirurgical, Phila., '12	79	98	92	76	79	81	90	86	85	766	85
3	Johns Hopkins, '12	84	100	96	93	78	94	93	92	91	821	91
4	University of Maryland, '12	75	100	85	97	80	75	78	86	90	766	85
5	Johns Hopkins	94	..	..	..	..	90	83	..	98	...	..
6	Howard University, '11	64	..	66	..	..	62	84	74	59	...	..
7	Jefferson Medical, '11	75	90	81	78	82	79	78	87	87	737	82
8	Johns Hopkins, '12	80	90	96	81	80	88	62	85	90	752	83
9	University of Maryland, '11	71	75	..	..	65	..	69	67	..	...	..
10	Women's Medical, Phila., '10	..	95	87	82	..	..	..	..	80	...	..
11	University of Maryland, '11	84	98	86	87	84	75	88	84	89	775	86
12	University of Maryland, '12	77	90	76	77	82	67	85	67	75	696	77
13	Johns Hopkins, '12	85	95	98	95	86	89	96	77	99	820	91
14	Johns Hopkins, '12	91	85	98	79	76	86	95	96	98	804	89
15	Johns Hopkins, '12	88	98	97	96	93	83	91	98	99	843	94
16	College of Physicians and Surg., Balto., '12	85	85	87	97	79	75	82	75	90	755	84
17	Johns Hopkins, '12	81	80	90	80	81	85	92	83	96	768	85
18	Maryland Medical, '12	71	57	75	76	67	71	90	66	77	650	72
19	College of Physicians and Surg., Balto., '12	84	80	77	96	79	75	83	78	87	739	82
20	Johns Hopkins	87	..	..	..	..	88	86	..	97	...	..
21	Johns Hopkins, '12	88	80	90	88	75	85	97	87	91	781	87
22												
23	Johns Hopkins	85	..	..	..	91	87	..	98	..	...	..
24	Johns Hopkins, '12	81	90	92	75	79	87	90	69	87	750	83
25	University of Maryland, '12	71	88	80	88	75	79	75	70	79	705	78
26	Maryland Medical, '12	68	85	85	90	67	84	91	82	77	729	81
27	Women's Medical, Penna., '12											
28	Johns Hopkins, '12	90	90	98	83	82	81	92	76	98	790	88
29	Johns Hopkins, '12	88	98	97	92	75	85	90	92	98	815	90
30	Johns Hopkins, '12	96	98	100	90	79	83	90	88	99	823	91
31	Johns Hopkins, '12	85	90	95	92	82	82	86	84	98	794	88
32	Johns Hopkins, '12	71	85	95	75	75	91	79	78	90	739	82
33	Johns Hopkins, '12	76	100	97	93	80	89	89	89	94	807	90
34	Johns Hopkins, '12	83	90	99	93	75	71	70	77	92	750	83
35	Johns Hopkins	88	..	..	..	82	80	..	84	..	...	..
36	Johns Hopkins, '10	77	90	92	88	75	79	82	98	65	746	83
37	Johns Hopkins, '12	76	90	99	96	75	85	75	75	78	749	83
38	Johns Hopkins, '12	91	90	100	77	75	83	82	79	99	776	86
39	Women's Medical, Phila., '10	60	70	60	78	66	70	67	75	56	602	67
40	Baltimore Medical, '12	87	90	90	97	75	90	85	90	92	796	88
41	Johns Hopkins, '12	86	90	93	93	79	80	77	94	93	785	87
42	Johns Hopkins, '12	89	90	99	94	85	85	85	88	97	812	90
43	Maryland Medical, '11	71	65	53	60	69	61	75	64	61	579	64
44	University of Maryland, '12	86	75	92	90	82	65	68	79	70	707	78
45	Johns Hopkins, '12	82	88	89	90	75	76	82	76	81	739	82
46	Johns Hopkins, '12	94	95	96	91	78	88	89	90	99	820	91
47	Maryland Medical, '12	88	95	86	91	77	82	89	92	86	786	87
48	University of Maryland, '12	75	90	81	94	75	80	79	84	80	738	82
49	University of Maryland, '12	94	90	96	97	87	90	88	94	88	824	91
50	Johns Hopkins, '12	84	95	94	78	78	78	85	82	97	771	86
51	Johns Hopkins, '12	83	100	100	98	85	92	86	98	99	841	93
52	College of Physicians and Surg., Balto., '12	82	95	80	96	82	80	81	94	77	767	85
53	University of Maryland, '12	47	90	79	70	75	71	50	60	72	554	62
54	University of Maryland, '12	94	85	88	89	75	79	75	88	85	758	84
55	Maryland Medical, '12	74	98	82	81	80	77	81	79	62	714	79
56	Johns Hopkins	60	..	..	..	..	78	71	..	94	...	..
57	University of Maryland, '12	54	85	77	79	75	75	59	67	63	634	70
58	Johns Hopkins, '12	79	85	95	92	75	85	76	92	91	770	85
59	University of Maryland, '12	80	90	88	89	75	75	67	84	68	716	80
60	Jefferson Medical College	79	..	..	..	..	81	67	..	63	...	..
61	University of Maryland, '12	84	90	96	92	78	80	76	74	75	745	82
62	Johns Hopkins, '12	86	85	98	87	80	85	82	81	99	792	88
63	Johns Hopkins	94	..	..	..	..	92	85	..	93	...	..
64	Johns Hopkins, '11	70	90	96	83	75	90	76	78	93	751	83
65	Johns Hopkins, '12	79	75	96	86	65	72	54	74	87	688	76
66	University of Maryland, '12	87	75	93	94	76	75	83	75	96	754	84

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland,
June 18, 19, 20 and 21, 1912.—(Continued.)

No.		Anatomy.....	Surgery.....	Pathology.....	Obstetrics.....	Practice.....	Chemistry.....	Maternal Medicine.....	Therapeutics.....	Physiology.....	Total.....	Average.....
	COLLEGE OF GRADUATION.											
67	University of Maryland, '05.....	75	..	78	..	..	..	..	..	..	..	..
68	Johns Hopkins, '12.....	87	78	100	95	80	86	83	94	99	802	89
69	Baltimore Medical, '11.....	75	..	..	..	..	75	75	..	..	..	..
70	Johns Hopkins, '12.....	82	95	99	94	78	84	87	84	97	800	89
71	Johns Hopkins, '12.....	80	100	100	97	82	77	75	96	95	802	89
72	Johns Hopkins, '12.....	88	85	100	98	82	81	92	90	98	814	90
73	Johns Hopkins, '12.....	74	90	96	91	75	89	71	64	85	735	82
74	Baltimore Medical, '11.....	72	..	67	..	..	..	..	72	67	..	..
75	Johns Hopkins, '12.....	91	90	98	93	77	79	79	86	97	790	88
76	Johns Hopkins, '12.....	75	85	96	75	75	85	83	82	88	744	83
77	Maryland Medical, '10.....	56	30	..	60	58	..	66	75	..	..	..
78	Howard University, '08.....	50	50	76	85	63	70	71	67	39	571	63
79	Johns Hopkins.....	68	..	..	..	..	77	70	..	85	..	..
80	College of Physicians and Surgeons, '12.....	82	82	98	90	64	82	60	71	68	697	77
81	Baltimore Medical, '08.....	85	..	..	..	75	76	76	86	..	..	..
82	Maryland Medical, '12.....	65	78	75	75	75	68	70	72	69	647	72
83	University of Maryland.....	82	..	..	..	..	88	92	..	82	..	..
84	College of Physicians and Surgeons, '12.....	81	95	87	90	75	67	76	73	75	719	80
85	Maryland Medical, '12.....	49	78	57	81	64	70	62	71	75	607	67
86	Maryland Medical, '12.....	77	75	66	87	59	67	43	61	67	602	67
87	University of Maryland, '12.....	89	95	94	92	82	79	93	90	87	801	89
88	University of Maryland.....	87	..	..	..	..	94	86	..	94	..	..
89	Woman's Medical of Phila., '11.....	76	..	85	..	..	..	76	85	..	..	..
90	Maryland Medical, '12.....	31	75	70	50	75	61	71	80	75	588	65
91	University of Maryland.....	87	..	..	..	..	87	86	..	95	..	..
92	University of Maryland, '12.....	75	80	91	81	83	81	78	76	79	724	80
93	University of Maryland.....	79	..	..	..	..	89	88	..	91	..	..
94	Johns Hopkins, '06.....	71	94	91	79	80	90	78	88	91	762	85
95	Johns Hopkins, '12.....	75	85	95	92	75	70	67	85	85	729	81
96	University of Maryland, '12.....	64	90	67	75	75	70	80	75	72	668	74
97	University of Maryland.....	87	..	..	..	..	89	75	..	82	..	..
98	University of Maryland, '12.....	64	92	93	94	75	75	75	87	86	741	82
99	Johns Hopkins, '12.....	66	75	82	79	44	57	43	49	85	580	64
100	Johns Hopkins.....	81	..	..	..	..	76	70	..	93	..	..
101	Baltimore Medical, '12.....	88	90	90	95	91	86	77	94	85	796	88
102	Maryland Medical, '12.....	50	60	61	90	75	70	66	75	75	622	69
103	University of Maryland.....	86	..	..	..	..	82	87	..	90	..	..
104	Maryland Medical, '12.....	79	75	74	75	75	66	60	69	62	635	71
105	University of Maryland.....	89	..	..	..	..	83	81	..	90	..	..
106	Maryland Medical, '12.....	76	85	88	95	78	86	80	80	88	756	84
107	Baltimore Medical, '12.....	84	83	82	92	75	81	68	82	83	730	81
108	Baltimore Medical, '12.....	75	90	86	83	82	82	87	88	88	761	84
109	Baltimore Medical, '12.....	80	86	83	95	80	81	76	83	76	740	82
110	Johns Hopkins, '12.....	83	70	100	89	84	88	81	89	94	778	86
111	Johns Hopkins, '12.....	83	94	88	94	75	78	82	87	89	770	86
112	Johns Hopkins.....	85	..	..	..	..	81	84	..	95	..	..
113	Medico-Chirurgical, Phila., '12.....	88	88	88	88	82	80	76	80	90	760	84
114	University of Maryland, '12.....	80	96	86	94	75	79	66	55	75	706	78
115	University of Maryland, '12.....	64	92	83	55	75	75	79	58	75	656	73
116	Johns Hopkins, '12.....	74	90	95	92	75	81	76	83	95	761	84
117	Baltimore Medical, '12.....	78	84	88	94	75	89	85	94	94	781	87
118	Johns Hopkins, '12.....	80	82	85	77	81	77	76	76	89	723	80
119	Maryland Medical, '12.....	23	65	33	70	48	55	33	37	36	400	44
120	University of Pennsylvania, '12.....	78	90	80	93	80	69	77	75	88	730	81
121	Jefferson Medical, '11.....	79	90	84	92	77	77	76	91	75	741	82
122	Virginia Medical, Richmond.....	..	..	..	..	..	75	64	..	71	..	..
123	Johns Hopkins, '12.....	76	75	97	80	61	82	77	77	96	721	80
124	Medico-Chirurgical, Phila., '12.....	82	85	87	92	80	80	77	85	92	761	84
125	University of Maryland, '12.....	72	55	75	88	80	73	63	69	85	700	78
126	College of Physicians and Surg., Balto., '12.....	64	80	71	89	75	61	63	70	62	635	70
127	College of Physicians and Surg., Balto., '12.....	70	85	65	75	61	85	80	88	66	675	75
128	College of Physicians and Surg., '12.....	..	..	..	..	..	..	..	..	..	..	..
129	College of Physicians and Surg., '12.....	57	70	85	75	60	64	62	81	52	606	67
130	College of Physicians and Surg., '12.....	83	75	76	86	75	77	70	65	75	682	76
131	Medico-Chirurgical, Phila., '12.....	85	92	92	83	88	79	75	86	89	769	85
132	Medico-Chirurgical, Phila., '12.....	74	75	85	75	82	79	81	75	95	721	80
133	Baltimore University, '07.....	71	88	79	66	68	89	75	73	75	684	76
134	Johns Hopkins.....	76	..	..	..	..	87	64	..	96	..	..
135	Johns Hopkins, '12.....	91	80	100	84	77	82	75	68	89	746	83
136	Baltimore Medical, '12.....	72	90	89	79	75	78	85	74	84	726	81

Failed to appear.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland,
June 18, 19, 20 and 21, 1912.—(Continued.)

COLLEGE OF GRADUATION.

No.		Anatomy.....	Surgery.....	Pathology.....	Obstetrics.....	Practice.....	Chemistry.....	Materia Medica.....	Therapeutics.....	Physiology.....	Total.....	Average.....
137	University of Maryland.....	83	..	..	..	86	90	..	84	...	...	..
138	Johns Hopkins, '12.....	93	94	97	90	78	87	83	84	100	896	89
139	Jefferson Medical, '12.....	..	..	..	..	Failed to appear.	..	..	..	..	..	..
140	Maryland Medical, '12.....	71	78	67	75	75	78	73	72	68	657	73
141	University of Maryland, '12.....	74	85	74	75	75	73	75	77	68	676	75
142	University of Maryland.....	65	..	..	..	76	57	..	..	44	...	..
143	University of Maryland, '12.....	76	84	87	94	75	75	80	75	80	726	81
144	Johns Hopkins, '12.....	75	80	100	90	80	85	84	92	97	783	87
145	Maryland Medical, '12.....	41	00	60	55	57	41	55	55	37	401	44
146	Maryland Medical, '12.....	32	70	50	81	68	72	70	58	51	552	61
147	Baltimore Medical, '12.....	89	85	91	80.	83	91	88	82	100	789	88
148	University of Maryland.....	87	..	..	..	78	67	..	76	...	...	..
149	University of Maryland.....	80	..	..	..	79	80	..	85	...	...	..
150	University of Maryland, '12.....	90	90	95	94	81	92	81	77	93	793	88
151	University of Maryland.....	73	..	..	..	80	75	..	84	...	...	..
152	University of Maryland, '12.....	92	80	97	94	84	75	87	81	75	765	85
153	University of Maryland, '12.....	77	84	96	91	79	88	84	92	86	777	86
154	Maryland Medical, '12.....	66	78	75	80	68	71	75	66	62	641	71
155	Baltimore Medical, '12.....	65	80	77	94	75	70	75	77	78	691	77
156	Baltimore Medical, '12.....	89	82	90	89	77	82	83	90	98	780	87
157	Maryland Medical, '12.....	54	93	80	78	69	76	72	80	75	677	75
158	University of Maryland, '12.....	91	80	72	91	75	65	79	75	85	713	79
159	University of Maryland.....	75	..	..	..	82	70	..	75	...	...	..
160	University of Maryland.....	63	..	..	..	71	54	..	57	...	...	..
161	University of Maryland.....	85	..	..	..	81	76	..	75	...	...	..
162	University of Maryland.....	84	..	..	..	75	75	..	96	...	...	..
163	University of Maryland, '12.....	89	84	99	92	75	88	75	96	89	787	87
164	College of Physicians and Surg., Balto.....	84	..	..	..	84	61	..	82	...	...	..
165	University of Maryland.....	90	..	..	..	89	66	..	83	...	...	..
166	University of Maryland, '12.....	83	84	85	91	82	85	86	87	85	768	85
167	University of Maryland, '10.....	..	..	82	..	..	75	..	78	...	...	..
168	University of Maryland, '12.....	..	..	..	..	Failed to appear.	..	..	..	..	..	..
169	Maryland Medical, '12.....	63	75	69	77	68	71	70	70	75	638	71
170	Maryland Medical, '12.....	42	63	51	50	57	66	48	38	46	461	51
171	University of Maryland.....	74	..	..	..	75	79	..	66	...	...	..
172	Temple University, '12.....	73	75	75	75	75	97	77	76	87	680	76
173	Baltimore Medical, '12.....	61	78	51	94	59	81	76	75	77	652	72
174	Temple University, '12.....	74	82	87	75	82	82	84	74	93	733	81
175	Maryland Medical, '06.....	67	..	59	..	..	..	..	..	..	...	..
176	Maryland Medical, '12.....	49	70	60	91	61	54	61	64	68	578	64
177	University of Maryland, '11.....	76	..	96	95	..	86	..	76	...	...	..
178	Maryland Medical, '12.....	41	50	56	83	63	58	48	69	65	533	59
179	University of Maryland.....	..	..	..	..	Failed to appear.	..	..	..	..	..	..
180	Maryland Medical, '10.....	64	40	55	70	65	85	70	62	75	586	65
181	University of Maryland, '12.....	80	87	86	93	75	86	69	74	93	743	83
182	George Washington University, '12.....	75	82	88	87	75	69	94	84	75	729	81

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who, at the end of their second year, have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology, are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second-year examination" are carried forward and made part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor.*

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A. SAMUELS, M.D.

BALTIMORE, SEPTEMBER, 1912

THE PITUITARY GLAND.

RECENT years have seen remarkable advances in our knowledge of the ductless glands. It is hard to believe that perversion of the functions of such small anlage as the suprarenals, parathyroids or pituitary can produce the extraordinary body changes attributed to them. A thorough realization of this fact by the medical profession was only brought about by the epochal investigations of Berthold on transplantation of the cock's testicle; by Bernard's classical observations on hepatic function, demonstrating the existence of an internal secretion (glycogen); by the immortal work of Addison, which attributed a definite clinical picture to disease of the suprarenal capsules, etc. With this information in hand it was a comparatively easy step to the conclusion that certain definite clinical syndromes followed either an increased or decreased secretion of the thyroid glands. The next step in the unweaving of the part played by glands of internal secretion upon the body was the determination that removal of the parathyroid rests produced tetany. To our mind, however, the most wonderful advancements in our conception of the importance of internal secretions are merely on the threshold. In this forward movement the protocols as enunciated (*The Pituitary Body and its Disorders*) by Harvey Cushing and his co-investigators at the Johns Hopkins University are pointing the way. The special field which Cushing has invaded is the determination of the functions of the pituitary and the evolution of medical and surgical processes for correction of any abnormality arising from perversion of its secretion. The work done by this group of investigators, both experimental and clinical, is of the most far-reaching importance, and by future generations will be looked upon as epochal in character. In the Hunterian Labora-

tory at the Johns Hopkins University by patient, diligent and painstaking experiments upon dogs, Cushing has definitely determined that the hypophysis cerebri may pour either too little or too much secretion into the body, as a consequence of which definite alterations occur in the structures of the body. If the secretion is minus in quantity, the secondary sexual characteristics of an adult will revert to the infantile type. The body will become fat, the vagina shrinks in size, the pubic hair falls out; if the secretion is below par in a child, the secondary sexual changes do not develop, the child remaining fat, pudgy and retaining its primary sex characteristics. If the gland is in a state of oversecretion, according to the age of the individual, gigantism (youth), acromegaly (adult) will result.

For many years it was the belief of investigators that acromegaly was due to a lessening of the secretion of the hypophysis, and it was Cushing, by his investigations upon hypophysectomized dogs, who proved the erroneousness of this hypothesis. In these animals it was shown that removal of the pituitary gland markedly increased their carbohydrate tolerance, a fact which was afterwards put to use clinically in determining whether the gland was under or over active. In those individuals suffering with a decreased secretion from the hypophysis it was found the carbohydrate intake was enormously increased without the appearance of sugar in the urine in sufficient quantity to reduce Fehling's solution. Cushing was also led from his investigations to the conclusion that even in those cases manifesting symptoms of oversecretion, that ultimately the gland would undergo degenerative changes, the symptoms of which are superimposed upon those of the overactive state. It was also determined that if there were an insufficiency of posterior lobe secretion, an injection of the extract from the anterior lobe would cause a rise in temperature. The X-ray in outlining the contour of the sella was found of immeasurable value in arriving at a proper diagnosis. As a contribution to scientific and practical medicine, the above monograph is model, and absolutely contradicts the assertion that animal experimentation contributes nothing of practical use to human surgery. The brochure contains a complete exposition of the anatomy, physiology, pathology, chemistry, clinical manifestations of disordered function, incidence, symptomatology and treatment. It is an unique and masterful piece of work, which will place the author among the medical immortals.

Medical Items.

THE following resolutions were adopted and ordered spread upon the minutes by the Anne Arundel County Medical Society at the regular quarterly meeting held at Annapolis, Md., Tuesday, July 9, 1912, to wit:

Resolved, Whereas God, in His infinite wisdom, has chosen to remove from our midst our friend and fellow-practitioner of medicine, Dr. Samuel Hall Anderson;

Resolved, That the Anne Arundel County Medical Society extends to the family of our deceased friend and fellow-practitioner, Dr. S. H. Anderson, their heartfelt sympathy in their hour of affliction.

Resolved, That a copy of these resolutions be forwarded to the family of the late Dr. S. H. Anderson.

Resolved, That a copy of these resolutions be published in the official organ of "The Medical and Chirurgical Faculty of Maryland."

Resolved, That a copy of these resolutions be published in the MARYLAND MEDICAL JOURNAL.

Resolved, That these resolutions be entered upon the minutes of this meeting held this ninth day of July, 1912.

Respectfully,

LOUIS B. HENKEL, JR.,

Secretary.

It is with deep regret that we announce the death of Dr. John Jay Taylor (Medico-Chirurgical College of Philadelphia, '87), founder and editor of *The Medical Council*, on August 1, 1912, of cancer, aged 59 years.

PRESIDENT TAFT has commissioned William Edward Fitch, M.D. (editor of *Pediatrics*, New York city), as first lieutenant in the Medical Reserve Corps of the Army of the United States, with rank dating from July 3, 1912.

DR. CLAUDE JACKSON STALLWAORTH has been elected resident physician at the Presbyterian Eye, Ear and Throat Hospital, succeeding Dr. William Gee.

MISS HELEN KELLER, in a speech to the Otologists' Congress, said that the late Dr. Chisolm of Baltimore was the first one to tell her parents of her true condition and to suggest plans for her education.

DR. R. S. SNOWDEN has received an appointment as resident physician at Bayview, succeeding Dr. Walter J. Baetjer, resigned.

DR. EUGENE B. WRIGHT, formerly superintendent of the Church Home and Infirmary, will succeed Dr. Chadbourne Andrews as

superintendent of the Hebrew Hospital, September 1.

THE Anne Arundel County Medical Society was entertained on August 13 by Dr. Joseph H. Brabham at his country home—"Brangwyn"—on the Severn River.

DR. CHARLES HOLLINGSWORTH has been appointed postmaster of Belair, Md., and will enter upon his duties about September 1.

DR. WINFORD H. SMITH is spending a vacation in Maine and Canada. In his absence Dr. Rupert Norton is acting superintendent of the Johns Hopkins Hospital.

DR. FREDERICK H. BAETJER has been suffering with an infected finger, which, it is thought, became infected during an operation. About three years ago Dr. Baetjer lost all of the fingers on his right hand but one by an accident with the X-ray machine.

DR. ELLIOTT H. HUTCHINS, Harvey B. Stone, R. A. Michaelson, Henry T. Collenberg and Joseph I. Kemler has been added to the staff of instructors at the College of Physicians and Surgeons.

THE little six-year-old daughter of Dr. B. M. Bernheim of Pikesville was internally injured by falling from the second-story window of her home.

THE new nurses' home, adjoining the Hebrew Hospital, is practically completed. It will be dedicated October 1. Its cost is approximately \$60,000.

DR. HARVEY CUSHING has returned from a visit to Germany and Austria, where he, in company with a party of American surgeons, attended a number of clinics. Dr. Cushing will take up his residence in Boston, September 1, and will assume his duties as professor of surgery in the Harvard Medical School. He has purchased the former residence of Mrs. Helen F. Bennett at 305 Walnut street, Boston.

DR. JOHN HOWLAND has been appointed director of the Harriet Lane Home for Invalid Children, and will assume his duties about September 15. Dr. Howland is a native of New York, a graduate of Yale University (B.A.) and of New York University (M.D.) and Cornell University (M.D., 1899). He served for a time as house officer in the Presbyterian Hospital in New York, and then in the New York Foundling Hospital. He then studied abroad for a year and a half and returned to the New

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BALTIMORE

York Foundling Hospital as pathologist and assistant attending pediatricist. He was for seven years instructor and associate in pediatrics in the College of Physicians and Surgeons of Columbia University. He then prepared in the leading children's clinics of Germany for his most recent position as professor of pediatrics in the Washington Medical School of St. Louis, from which he comes to Baltimore.

DR. JAMES BOSLEY has returned from a visit to the Bermudas.

DR. CHARLES BEVAN has resigned as dean of the College of Physicians and Surgeons and has been succeeded by Dr. William F. Lockwood, formerly professor of the principles and practice of medicine.

AMONG the medical men who are spending a vacation out of town are Dr. Geo. Reuling, at Narragansett Pier; Dr. William B. Thayer, in Switzerland; Dr. Ernest Gaither, in Germany; Dr. Thomas S. Cullen, in Ontario, Canada; Dr. John Staije Davis, at York Harbor, Me.; Dr. James J. Hill, in England; Dr. Waitman T. Willey, in New York; Drs. C. T. Scudder and C. I. Woolford, in Atlantic City; Dr. Arthur Wegefarth, in Canada; Dr. Pearce Kintzing, in Germany; Dr. Heiskell, in Union, N. Y.; Dr. James J. Hill, in Europe; Dr. William H. Welch, in Bedford Springs, Pa.; Dr. John A. Tompkins, at Rye Beach, N. H.; Dr. John G. Huck, in Spring Lake, N. J.; Dr. R. N. Owens, at Saranac Lake, N. Y., and Dr. H. E. Peterman, at Cherry Tree, Pa.

THE engagement is announced of Dr. Maurice Eubanks Broadas Owens, University of Maryland, '10, of Long Lake, Washington, and Miss Maysville Jane Freeman of Baltimore. The wedding will take place in Spokane, Washington, September 1, at the residence of Dr. A. Aldridge Matthews, who is well known in Baltimore.

DR. JOHN R. CAULK of St. Louis, Mo., has announced the engagement of his sister, Miss Mary Wrightson Caulk, of Easton, Md., to Dr. Arthur Bond Cecil of Baltimore. Dr. Cecil was formerly a surgeon in the Navy, but is now assistant to Dr. Hugh H. Young.

MARRIAGES.

GAIUS WILLIAM BILLUPS, M.D., University of Maryland, '06, to Mrs. Josephine Mullin Long, both of Baltimore, at Baltimore, July 24, 1912.

JAMES EDWARD HUBBARD, M.D., University of Maryland, '12, of Baltimore, to Miss Lillian E. Godwin of Easton, Md., at Easton, July 17, 1912.

B. PHILIP HERZOG, M.D., Baltimore Medical College, '06, of Baltimore, to Miss Lucille Doerner of Cumberland, at Cumberland, July 2, 1912.

DEATHS.

SAMUEL GEORGE MCCLELLAN SNYDER, M.D., Baltimore University School of Medicine, '88, died at his home in Altoona, Pa., June 12, 1912, from nephritis, aged 49 years.

JAMES RAY LIGHT, M.D., Maryland Medical College, '09, of Lebanon, Pa., died at North Annville Township, July 9, 1912, following a hemorrhage, aged 38.

WILLIAM PORSONS IVEY, M.D., University of Maryland, '83, died at his home in Lenoir, N. C., June 28, 1912, from cerebral hemorrhage, aged 55 years.

ELLWOOD HUGGINS, M.D., Baltimore Medical College, '88, died at his home in Baltimore, July 28, 1912, from cerebral hemorrhage, aged 64 years.

JOHN BARRON, M.D., University of Maryland, '77, died at his home in Baltimore, August 2, 1912, from heart disease, aged 70 years. Dr. Barron was for over thirty years a practitioner of Govanstown, Md.

JOHN ADDISON MOORMAN, M.D., University of Maryland, '68, died at his home in Hendrick's Store, Va., July 16, 1912, from nephritis, aged 68.

JOHN SMALLBROOK HOWKINS, M.D., University of Maryland, '97, died at his home in Savannah, Ga., May 25, 1912, aged 54 years.

GEORGE W. SIMPSON, M.D., College of Physicians and Surgeons, '72, died at his home in Baltimore, August 18, 1912, of heart disease.

CHARLES H. ROSE, M.D., Hahnemann Medical College of Philadelphia, '55, for over fifty years a practitioner of Cordova, Md., died at the home of his daughter in Centerville, Md., August 23, 1912, aged 79 years.

WILLIAM KIRKWOOD ROBINSON, M.D., University of Maryland, '93; Johns Hopkins Medical School, '95, died at his residence, 306 Kingsley Drive, Los Angeles, Cal., August 26, 1912, aged 43 years.

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WOUNDS INFLICTED BY THE MODERN RIFLE.*

By R. G. Heiner, M.D.,

United States Naval Hospital, Annapolis, Md.

GENTLEMEN—Having been asked to read a short paper on wounds caused by the modern rifle, I take leave to present to you my own opinions along with some of the most versed in the subject, as Makin Lynch and others.

Since the Spanish-American war our theories in regard to the modern rifle have entirely changed. Before that time it was said that it would be a more humane instrument of warfare, as on account of the small cross section of the bullet and its high velocity it would only damage tissues actually in its path, leaving a small canal, the sides of which would fall together in good position for healing, and there would be no infection on account of the bullet being sterilized by the heat produced in its rapid flight. Consequently, if no important structures were in the path of the bullet, a rapid and complete recovery was to be expected. However, such is not the case.

Experience has proven that our modern high-power rifle is very destructive, producing far more extensive injuries than the old-style weapon.

The explosive effect caused by the high velocity was not considered, and experiment has proven that the temperature of the projectile is not raised enough to kill any germs that may be lodged on it.

The modern rifle is sighted up to 3000 yards, but is generally used at a range of under 1200 yards; although, of course, a great many wounds occur beyond that distance.

For description wounds may be divided into those received at ranges under 500 yards, between 500 and 1200 yards, and beyond 1200 yards.

In wounds received at ranges of under 500 yards, the explosive effects are noted on all tissues; the closer the more severe. At

*Read before the Anne Arundel County Medical Society August 13, 1912.

very close ranges even muscles are pulphified, the bullet carrying with it a cone shaped mass of tissue, with its apex corresponding to the wound of entrance, and its base sometimes three or four inches in diameter, corresponding to the wound of exit. Traumatic aneurisms are caused in the adjacent vessels and the shock is transmitted to the entire member. Bones are pulverized; frequently the whole shaft of a long bone, and in case of solid organs, as liver, kidneys, brain, etc., complete destruction occurs. At close range brain wounds are 100 per cent. fatal.

Between 500 and 1200 yards the wounds are more likely to be perforative, and the damage lies only in the track of the bullet; the nearer you get to 1200 yards the more clean cut the perforation.

Over 1200 yards, when the bullet loses its steadiness and begins to wobble, you have another entirely different class of wounds. The bullet still has enough velocity to perforate and is wobbling, tumbling or traveling side on, on account of which it produces extensive lacerations to soft parts and shattering of bones, but there is no explosive effect.

From the foregoing it will be seen that at nearly all ranges this modern arm is very destructive.

To illustrate, I will now read a report written by me in 1906 of some cases of gunshot wounds I treated about that time, and will then criticise it from my present point of view.

It reads as follows:

U. S. S. Scorpion, Monti Cristi, Santo Domingo.—In obedience to your order of February 22, 1906, I have to make the following report of the services rendered by me on shore at Puerto Plata, Santo Domingo.

I went ashore there under the protection of the red cross flag on January 2, 1906, accompanied by hospital apprentice, first class, J. J. Gleason; ordinary seaman H. V. Dean, and fireman, first class, W. Hamlin. We worked together for about fifteen days, going ashore every morning between eight and nine, and on several days working until an hour or so after dark.

The first morning, after looking around, I took up my station at the Military Hospital in the lower part of the town, near the fort. It was a large and airy one-story structure, divided into about ten rooms. One native doctor was doing what he could in the way of dressing, etc., but as he had no knowledge of surgery and did not seem to have any idea of organization, he gladly accepted my assistance which I offered. We set aside one room for operating, in which we put a wooden table and improvised stands for instruments. There were facilities for boiling water, and with my alcohol lamp and sterilizer we prepared to do whatever operative work came along.

The first case was a man who had a wound caused by a 57-caliber lead bullet, which passed through the left side at the tenth rib, fracturing it and driving pieces of it into and through the

spleen. The bullet passed through and came out behind, below the twelfth rib and to the left of the spine. This man was almost exsanguinated when I saw him and died in a few minutes.

Next was a case in which a 57-caliber lead bullet had passed through the abdomen; wound of entrance one-half inch to the left of the rectus, about on a level with the navel and wound of exit below twelfth rib behind. As the descending colon was in line of bullet, I opened the abdomen and found it cut completely across. I did an intestinal anastomosis, Connell's method; provided for drainage and dressed. As it was dark we quit for the day.

The next day we started up another little hospital in the upper part of the town in a vacant house owned by the Cuban Minister, which he kindly offered to us for the purpose. The Red Cross furnished us with beds, food and nurses.

We took eight of the worst cases and treated them here. They were as follows:

Two compound fractures of the femur, one of which was caused by a 57-caliber lead bullet and was infected; the other was caused by a Mauser 30-caliber, and was clean. The latter was put up in a flexible wooden splint and an extension apparatus applied. The former case had a large amount of pus in the tract of the wound and was treated by extension and an easily removable wire gauze splint, so that it could be dressed each day.

Two wounds of the thorax, passing through the right side of the chest and penetrating the right lung, caused by 30-caliber Mauser bullets. Wounds of entrance and exit were clean, and they were covered with sterile dressings and left alone.

One wound caused by bullet passing through neck from side to side, probably between the vertebral column and pharynx. Sterile dressings applied.

One case in which a 30-caliber bullet passed to the inner side of the anterior superior spinous process of the ilium and came out behind between the trochanter major of the femur and the tuberosity of the ischium. This bullet must have passed through the acetabular cavity. Sterile dressings applied.

One case of lacerated wound of the hand, just below the wrist, with gangrene. Amputated just above wrist. The same case had a wound probably caused by a 30-caliber Mauser bullet which entered behind, on the left side, at the angle of the lower jaw, shattering it from about the ramus to the canine tooth and making a long slit in the lower lip. Cleaned out pieces of bone and did a plastic operation on the lip.

A case of gunshot wound of the toes with gangrene. Tarso-metatarsal amputation. The next day symptoms of tetanus developed, and although we amputated above the ankle and did lumbar puncture, injecting 10 c. c. of anti-tetanic serum into the cord and 50 c. c. under the skin, the man died in 48 hours.

To go back to the Military Hospital, where we continued our

work. We had here two more cases of compound fracture of the femur, both of them having been infected before they were brought in. One of these was caused by a 57 and the other by a 30-caliber bullet. We dressed each every day, and the one caused by the 30-caliber bullet did well, but the other one we had to open wide for drainage, and as so much bone sloughed away it was necessary to amputate.

One case of gangrene of the forearm, due to injury of the brachial artery above the elbow by a bullet passing through the arm, was seen. The arm had to be amputated.

Compound fracture of the tibia and fibula was treated before anyone had a chance to infect it with a dry aseptic dressing and splints.

Several cases of simple wounds dressed and healing nicely.

Extracted quite a number of spent bullets from under the skin.

To sum up we had as follows:

One wound of spleen, rapidly fatal.

Four compound fractures of the femur, three of which came out well, with only slight shortening. The fourth has a good stump.

One case of intestinal anastomosis; doing well.

Two penetrations of the chest passing through lung; both entirely well.

One wound of neck, bullet passing through; entirely well.

One case of bullet passing through hip joint, smashing acetabular cavity; ankylosis in useful position.

One case of gunshot wound of foot, followed by tetanus; died.

One amputation of arm for traumatic gangrene; good stump.

One case of compound fracture of leg; now has a perfect leg.

One case of shattered lower jaw and lacerated lip; small scar of lip and can use right side of jaw.

Many dressings and minor operations.

You all present at this meeting will wonder, as the captain of my ship did, at the time of this report, how I was able to state so exactly that some wounds were caused by 57-caliber lead and others by 30-caliber jacketed Mauser bullets.

My explanation was that there were only two kinds of arms in use at the time of the battle—a few old-style 57-caliber carbines and the Mauser rifle, so I concluded that the large wounds were due to the 57-caliber and the small clean-cut perforations were due to the 30-caliber.

In looking back and reasoning out from facts since gained, I am of the opinion that all my wounds were due to the 30-caliber Mauser rifle, and that the many variety of wounds that I had were due to the different ranges at which the wounds were received.

The foregoing report is of the wounded from both sides in a battle lasting two days with about 1000 engaged, and it takes no account of the dead.

You will note that the injuries to solid organs, as liver, brain,

etc., are conspicuous by their absence. Why? Because as I stated before, on account of the explosive effect, which is most marked on solid organs, they are 100 per cent. fatal at short ranges, and this battle was fought at short ranges.

In conclusion, I would say that in treating wounds caused by the modern arm you must be prepared for almost any conceivable form of injury, and that the expectant plan of treatment is best, except where you know that intestines, large blood vessels, etc., are in line of the bullets' path and must have been injured.

THE SURGICAL CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO. Volume I, No. 4, August, 1912. Illustrated. Philadelphia and London: W. B. Saunders Company. Published bi-monthly. Price per year: Paper, \$8; cloth, \$12. Baltimore: The Medical Standard Book Co.

The scope of Murphy's "Surgical Clinics" should be sufficiently well understood by the profession to obviate the necessity of a long and fulsome laudation, thus enabling us to get down to concrete examples of what the issue contains. No one will deny that the scheme of publishing the remarks as actually made at the Mercy Hospital is one of the best possible methods of teaching surgery, and giving those who cannot find the opportunity to attend a way to obtain useful, practical material from one of the foremost surgeons in America. The present number contains remarks on acute appendicitis and pneumonia; chronic appendicitis; ankylosis of the knee; arthroplasty; joint infections; angio-plebitis of leg and thigh—old muscular hemangioma; hypertrophy of the prostate; nephropyloplasty; ankylosis of the left elbow joint—fracture of joint with deformity; tumors of the abdomen—retroperitoneal sarcoma; concussion of the spine with impacted fracture of the vertebrae; traumatic epilepsy; decompression; transplantation of bone (osteitis fibrosa cystica); carcinoma of the lip; carcinoma of the splenic flexure of the colon—intestinal obstruction, and students' clinic fractures. Those interested in bone surgery, especially the method of correcting ankylosed joints and the results, will find very interesting and instructive reading in the section on ankylosis of the left elbow joint. Murphy is a pioneer in this field of surgery, and his methods are being pursued by ever-increasing numbers as they become acquainted with his technique. The other sections are likewise intensely practical and contain many useful hints both in diagnosis and treatment.

THE MILK PROBLEM.

By H. W. Stoner, M.D.

FORMING as it does the most extensively used of foodstuff with the exception of bread by all classes of people, the necessity of securing milk as pure and wholesome as possible is apparent to every intelligent person. This fact is more emphasized when it is considered that milk, in a large number of cases, is almost the exclusive diet of the sick and of many infants, to whom, should it contain deleterious material, it might become a very dangerous food and do much harm. In 1908 the City Council of Baltimore passed a set of ordinances placing the control of the milk supply under the Commissioner of Health, vesting him with full power to enforce the laws. That these laws have had some effect toward improving the condition of the milk supply of Baltimore and in reducing the death rate from intestinal diseases among infants is shown in the accompanying table, but, unfortunately,

TABLE showing the number of deaths from diarrhea and enteritis of children under two years old in Baltimore in two three-year periods, from June 1, 1905-June 1, 1908, before the milk ordinances went into effect, and from June 1, 1908-June 1, 1911, since milk ordinances have become effective.

	Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Total.
1905.....	..	..	..	..	..	108	305	160	67	49	13	11	713
1906.....	5	6	4	2	14	70	269	121	77	37	11	7	623
1907.....	7	8	8	9	8	28	244	235	125	48	17	10	747
1908.....	9	8	12	8	15	..	..	..	..	..	..	..	52
													2135
1908.....	..	..	..	..	..	86	246	114	54	27	11	1	539
1909.....	6	7	7	11	11	52	188	136	77	43	22	2	562
1910.....	10	7	6	11	12	50	187	143	79	58	29	8	598
1911.....	16	11	15	9	32	..	..	..	..	..	..	..	83
													1782

The table shows that there were 353 more deaths from diarrhea and enteritis in children under two years of age during the first three-year period, before the passage of the milk ordinances, than in the three-year period following the passage of the ordinances. The fact that there has been an estimated increase in population of 24,000, with a correspondingly increased number of children under this age, in the latter period must not be overlooked.

summer diarrhoea is not the only malady conveyed through milk, and such diseases as tuberculosis, typhoid fever, diphtheria, scarlet fever, septic sore throat, etc., may also lurk in this innocent appearing fluid. The medical literature abounds with histories of epidemics of these diseases that have been traced to milk. It is not to be assumed that the passage of the aforementioned laws has had no effect in reducing these diseases, for they have had, beyond a doubt; but, while they have done much toward improving conditions, an article so widely used as milk, and one that plays such an important rôle in the health of the public, should be guarded with the strictest care, and any practical means toward its improvement should receive the utmost consideration.

Until the present summer Baltimore has had no fixed bacteriological standard for controlling the condition of its milk supply, and, while bacteriological examinations have been made and

dealers notified when the samples under consideration contained an excessive number of bacteria, no legal standard has been recognized, and no effort has been made to bring the person selling such milk to task.

That the bacteriological test of milk is the best guide we have as to the quality of a supply is beyond controversy. An excessive number of bacteria in a given specimen of milk indicates dirty or filthy conditions on the dairy farm, carelessness in the collection and handling of the milk, the use of dirty milk utensils or improper refrigeration of the milk while en route to the city. It indicates even more: it indicates that the person producing such milk is not only careless in its production, but that he is apt to be careless in other matters, in matters that may affect the health of the individuals using the milk. He is likely to pay little attention to the health of his dairy herd, little attention as to whether or not the persons handling the milk are in perfect health or are intimately associated with persons having infectious diseases; as to whether the water used in cleansing the utensils is free from pollution, and thus the route for the transmission of disease is open. Many epidemics of typhoid fever have been traced to individuals convalescent from this disease having handled the milk, or to individuals having been intimately associated or even having nursed some one with this disease while handling the milk. The same thing also applies to such other diseases as tuberculosis, diphtheria, scarlet fever, intestinal dysentery, etc., and the careless milk producer whose milk contains high bacterial counts is usually the one who could have prevented the spread of these diseases.

During the present summer the Milk Committee of the Women's Civic League started a crusade for a better milk supply, and after several conferences with the Mayor, Health Commissioner, City Chemist and City Bacteriologist it was decided that a bacteriological standard be required of all milk sold within the city. This standard allows as the maximum not over 500,000 bacteria per cubic centimeter for raw milk, and not over 50,000 bacteria per cubic centimeter for all pasteurized milk. That these requirements will improve our milk supply cannot be questioned, but there is still room for greater improvement. Why should the dealers in raw milk be allowed to sell a commodity containing ten times the number of bacteria that is contained in the milk sold by the dealers selling pasteurized milk? If milk can be produced containing 50,000 bacteria per cubic centimeter or under and sold at a reasonable price, why not have all our milk pasteurized? Why should certain individuals through ignorance, mistaken ideas on the subject, or, more probably, through greed, be allowed to sell milk not meeting these requirements? New York and Chicago require all milk to be either pasteurized or certified, and the scheme is working very successfully in both cities.

Trask¹ has collected from the literature 317 epidemics of typhoid fever, in which over 15,000 persons were attacked with this disease; 125 epidemics of scarlet fever, with 7276 cases, and 51 epidemics of diphtheria, in which 2857 persons were infected, all of which were traced directly to milk.

In a recent investigation of the milk supply of London,² 7895 samples of milk were examined for the tubercle bacillus, and the organism was found in 850, or in 10.8 per cent., of the samples. Of 44,307 cows examined, 574, or 1.3 per cent., were found to have tuberculosis of the udder. Of 1701³ cattle tested with tuberculin in the District of Columbia by the Bureau of Animal Industry in 1910, 321, or 18.87 per cent., gave a positive reaction. All the animals giving a positive test were killed, and post-mortem examinations showed the presence of tuberculosis in all but five. During the same year 343 animals were tested with tuberculin by the same officials in Maryland, and 15.74 per cent. gave positive reactions. In Virginia 1100 were tested, and 18.27 per cent. gave positive tests.

If we stop for a moment to consider these figures, the conclusions we must arrive at are startling. Over 29,000 gallons of milk are consumed in Baltimore daily, and of this quantity about 12,000 gallons are pasteurized and 17,000 gallons are sold in the raw state. The above figures would indicate that over 15 per cent., or more than 1100 gallons, of raw milk from tuberculous cattle are consumed in this city every day of the year. How in the world can we ever hope to eradicate tuberculosis from our midst with this prolific source of infection being delivered daily at our doors?

Dr. Park of the New York Health Department has examined 787 tuberculous adults, and found that 777 were suffering from the human and 10, or 1.2 per cent., with the bovine type of tuberculosis. Of 153 children between the ages of 5 and 15 examined, 117 had human and 36, or 27 per cent., the bovine form of the disease. From birth to 5 years of age 281 were examined, and 216 showed the human and 65, or 23.5 per cent., the bovine type of the disease.

It will be seen from the above that it is the children who are the ones most apt to become infected from milk from tuberculous cattle. Is it any wonder that our tuberculous death reports show that the large majority of deaths from this disease occur at the age when our young men and women should just be entering into a useful life?

The death rate among infants under 1 year of age in New York City from June 15 to October 1, 1910, was 17 per cent. In 1911 the Health Department of New York established 15 milk stations, supplying pasteurized milk for the poor. From April 22 to October, 1911, 3829 babies were supplied with pasteurized milk from these stations. The number of deaths occurring among these 3829 were 49, or 1.3 per cent.

It is well known by everyone having any familiarity with the

subject that the disease producing bacteria, such as *B. typhosus*, *B. dysenteriae*, the Streptococci, *B. tuberculosis*, *B. diphtheriae* and other organisms, are all destroyed in milk that has been properly pasteurized, whereas raw milk furnishes one of the most favorable mediums for the propagation of these germs. The laboratory experiments that have been carried out and proven this fact are too numerous to mention. It will be argued that laboratory experiments are not infallible, and sometimes fail when applied practically. In August of last year a series of six practical experiments were made by three bacteriologists working under and with the assistance of Dr. Park, director of the Research Laboratory, Department of Health, New York, at an abandoned pasteurizing plant located at 130th street and Broadway, New York. The results of these experiments would indicate that *B. typhosus*, *B. diphtheriae* and *B. tuberculosis* are killed in milk when pasteurized under commercial conditions if the process is properly carried out. These experiments are briefly described as follows:

Experiment No. 1.—One hundred and fifty gallons of milk were inoculated with 3000 c.c. of a 48-hour-old broth culture of *B. typhosus* containing 600,000,000 typhoid bacilli to the cubic centimeter. The milk was pasteurized at a temperature of 149° F. to 152° F. and kept in the holding tank for one hour. Samples were taken from the holder at the end of 8, 15, 30, 45 and 60 minutes. All specimens were found to be free of living typhoid bacilli. The experiment shows that the typhoid bacillus is killed when milk is pasteurized at a temperature of 149° F. to 152° F. and kept in the holder for 8 minutes or longer.

Experiment No. 2.—One hundred and fifty gallons of milk were inoculated with 3000 c.c. of a 48-hour-old broth culture of *B. typhosus* containing 1,000,000,000 typhoid bacilli to the cubic centimeter. The milk was pasteurized at a temperature varying from 140° F. to 144° F. and kept in the holding tank for one hour. Samples of the milk taken from the holder at the end of 15, 30, 45 and 60 minutes contained no living typhoid bacilli. The experiment shows that the typhoid bacillus is killed when milk is pasteurized at a temperature between 140° F. to 144° F. and kept in the holder for 15 minutes or longer.

Experiment No. 3.—Six hundred gallons of milk were inoculated with 2450 c.c. of a 24-hour-old broth culture of *B. typhosus* and 2000 c.c. of a mixture of *B. tuberculosis* (human and bovine) in human tuberculous sputum. The milk was pasteurized at a temperature ranging from 132° F. to 150° F. and kept in the holding tank for one hour. Samples of the milk taken from the outlet of the pasteurizer and from the holder at the end of 20, 30, 45 and 60 minutes were free of living typhoid bacilli. Seven of 10 guinea pigs inoculated with the milk before pasteurization showed generalized tuberculosis when chloroformed three months later, the other three animals having died of general acute infec-

tions in the interim. Four guinea pigs inoculated with milk taken from the outlet of the pasteurizer, 2 inoculated with milk taken from the holder at the end of 20 minutes, 2 inoculated with milk taken from the holder at the end of 30 minutes, 2 inoculated with milk taken from the holder at the end of 45 minutes and 4 inoculated with milk taken from the holder at the end of an hour were all chloroformed at the end of three months and showed no evidence of tuberculous infection. The experiment shows that both the typhoid bacillus and the tubercle bacillus are killed in milk when the latter is pasteurized at a temperature not exceeding 150° F.

Experiment No. 4.—One hundred and fifty gallons of milk were inoculated with 3000 c.c. of a 48-hour-old broth culture of *B. diphtheriae* containing 64,400,000 diphtheria bacilli per cubic centimeter. The milk was pasteurized at a temperature ranging between 144° F. and 148° F. and kept in the holder for one hour. Samples taken from the outlet of the pasteurizer and from the holder at the end of 15, 30, 45 and 60 minutes contained no living diphtheria bacilli. The experiment shows that the diphtheria bacillus is killed in milk when the latter is pasteurized at a temperature not exceeding 148° F.

Experiment No. 5.—One hundred and fifty gallons of milk were inoculated with 3000 c.c. of a 48-hour-old broth culture of *B. diphtheriae* containing 54,800,000 diphtheria bacilli to the cubic centimeter. The milk was pasteurized at a temperature ranging between 140° F. and 145° F. and kept in the holder for one hour. Samples taken from the outlet of the pasteurizer contained from 500,000 to 1,000,000 bacteria per cubic centimeter. Of two samples taken from the holder at the end of 15 minutes, one contained 50,000 bacteria and the other was free from diphtheria bacilli. Samples taken from the holder at the end of 30, 45 and 60 minutes contained no living diphtheria bacilli. The experiment proves that the diphtheria bacillus is killed in milk when the latter is pasteurized at a temperature not exceeding 145° F. and the milk is kept in the holder 30 minutes or over.

Experiment No. 6.—Six hundred gallons of milk were inoculated with 4000 c.c. of a 48-hour-old broth culture of *B. typhosus* and 1800 c.c. of a broth culture of *B. diphtheriae*. The milk was pasteurized at a temperature ranging between 134° F. to 143° F. and kept in the holder for one hour. Samples taken from the outlet of the pasteurizer contained from 70,000 to 370,000 bacteria per cubic centimeter. Of two samples taken from the holder at the end of 15 minutes, one contained 12,000 bacteria per cubic centimeter and the other was free from bacteria. Of two samples each taken from the holder at the end of 30, 45 and 60 minutes, all were free from typhoid or diphtheria bacilli. The experiment proves that both *B. typhosus* and *B. diphtheriae* are killed in milk when the latter is pasteurized at a temperature not

exceeding 143° F. and kept in the holder for 30 minutes or longer.

Schorer and Rosenau⁴ have carried out a set of similar experiments under the auspices of the Committee of Milk and Baby Hygiene of Boston. These investigators used 100 gallons of milk in each of their experiments, and found also that the three organisms mentioned above, *B. typhosus*, *B. tuberculosis* and *B. diphtheriae*, were all killed when the milk was pasteurized at a temperature of 142° F. and held at 140° F. for 20 minutes.

It is argued by the raw-milk advocates that the pasteurization of milk is only a makeshift; that it allows the man who produces dirty milk to continue in his filthy ways; that is, provides the dealer with means for disposing of milk after it has become old, and that it delays the realization of the ideal production of milk. But shall we, in striving for the ideal, forget actual conditions as they exist? Shall we allow our babies to die of infantile diarrhea, diphtheria and scarlet fever; allow the spread of consumption by tuberculous cattle to carry off our children just at the time they are blossoming into manhood and womanhood; allow epidemics of typhoid fever to kill off our men and women at the most useful period of their existence while we are trying to educate the ignorant or careless dairy farmer to the necessity of sanitation and convince the ignorant or mercenary milk dealer of the dangers lurking in his milk? If not, let us have pasteurized milk, and not let milk be sold in our city containing 2,000,000 bacteria to every teaspoonful (500,000 per cubic centimeter), perhaps many of them carrying disease or death, when milk can be and is being produced and sold free from these dangers.

Not only will the pasteurization of our milk supply reduce our morbidity and mortality, but it will also do much toward bringing about the ideal conditions on the dairy farm. The excuse of the dairy farmer when approached in regard to improved hygienic conditions in the production of milk is that "he cannot afford to make changes on account of the low price of milk." In an address before the Chamber of Commerce of Rochester, N. Y., on the "Production of Milk at a Reasonable Rate," Dr. John R. Williams,⁵ after pointing out that among some of the reasons milk could not be produced at a reasonable price was in some instances due to the fact that valuable land near cities was used for dairy purposes, making the overhead charges too great, said that in other instances large areas of land were being used for pasture when by a more intensive method of feeding the same number of cattle could be fed at much less cost, etc. He called particular attention to the fact that the multiplication of the small retailers and distributors of food is recognized as one of the high costs of living, and in the sale of milk the overlapping of routes of distribution by a large number of small dealers contributes not a little to the high price of this article, and that the elimination of these small distributors would result in a cheaper milk

for the consumer and a better price for his product for the dairy farmer.

PASTEURIZED MILK.

We have pasteurized milk and pasteurized milk, *i. e.*, not all the milk sold in Baltimore is perfectly pasteurized. The records of the Health Department show that some of the so-called pasteurized milk sold in the city would not meet the bacteriological standard required of raw milk. Unfortunately, some of our larger milk dealers are content with merely passing the milk through a pasteurizer and labeling it "Pasteurized Milk." The proper pasteurization of milk requires care and intelligence. To be wholesome and free from danger a pasteurized milk should be clean and have a low bacterial count before it is pasteurized; it should have been kept cool (50° F. or under) from the time it leaves the dairy until it enters the pasteurizer; the pasteurizer, holder, pump, bottling machine and all pipes should be rendered as near sterile as possible just before and immediately after each run of milk; the milk bottles should also be as near sterile as possible and kept so until used; the water supply should be above suspicion; the milk should be pasteurized at an equable temperature, and at a temperature that insures the destruction of all pathogenic bacteria (142° F. to 145° F.); the milk should be kept in the holder at least half an hour; the heated milk should be cooled immediately after the period of holding has elapsed to 50° F. or below and kept at this temperature until it reaches the consumer. All employes should be subject to medical examination at regular intervals, and any contagious disease in an employe or his family should immediately be reported to the Health Department. The whole pasteurizing plant should be kept perfectly clean and in a hygienic condition. Pasteurized milk should receive the same care as raw milk under all conditions.

In the experiments of Schorer and Rosenau⁶ cited above, it was found that at least seven minutes were required before an automatically-controlled pasteurizer heats the milk uniformly. They also found different layers of milk in the holding tank to vary in temperature, the warmer milk rising to the top. This variation in temperature ranged from 13.4° F. to 40° F. They recommend that the pasteurization of milk should not be hurried; that the first 10 minutes' run be repasteurized; that several holding tanks be used, the first to act as an equalizer and the others to hold the milk at a uniform temperature, and they emphasize the necessity for official control over pasteurizing plants, as when the pasteurization is left to the caprice of an individual there is danger of underheating and false security.

It is earnestly hoped that the Women's Civic League will not remain content with the good work they have started, but that they, with other civic bodies, will make every effort to secure for Baltimore a pasteurized milk supply with all pasteurizing plants under municipal inspection.

REFERENCES.

¹Trask, Bulletin No. 56, U. S. Public Health and Marine Hospital Service.

²*Journal American Medical Association*, lviii., 1912, p. 1456.

³*Annual Report Bureau of Animal Industry*, 1910, p. 73.

⁴*Journal Medical Research, Boston*, 1912, xxvi, p. 127.

⁵*Journal American Medical Association*, 1912, lviii, p. 1290.

⁶*Journal Medical Research, Boston*, 1912, xxvi, p. 127.

210 Professional Building.

LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY.

By L. Bathe Rawlings, M.B., B.C. (Cant.), F.R.C.S. (Eng.); Surgeon with Charge of Out-Patients, Demonstrator of Practical and Operative Surgery; Late Senior Demonstrator of Anatomy at St. Bartholomew's Hospital; Late Assistant Surgeon to the German Hospital, Dalston; Late Hunterian Professor, Royal College of Surgeons, England, etc. With 31 illustrations. Fifth edition. New York: Paul B. Hoeber. 1912. Cloth; \$2 net.

This book, as indicated by the title, is devoted to the surface markings on the body. Chapters are given over to the head and neck, the upper extremity, the thorax, the abdomen. Do not get a mistaken idea from the caption that all landmarks are described; such is far from the truth, only those being given which are of practical value. Perhaps too little attention has been devoted heretofore to this important subject. At any rate, in operative procedures much worry can be obviated by an appreciation of the external topography of the body. Certain markings lead directly to the affected organ, whilst the slightest deviation from these markings lead the operator into a quagmire of difficulty. Anatomic and surgeon apprentices will be benefited by a careful reading of the book, which is written in easy style and attractive English.

THE CARE OF THE SKIN AND HAIR. By William Allen Pusey, A.M., M.D., Professor of Dermatology in the University of Illinois. New York: D. Appleton & Co. 1912.

Too little is known by the doctor concerning the proper hygiene of the skin, and, as every practitioner is fully aware, there are many minor skin affections for which his patients seek advice, with, in many instances, embarrassment to the physician if he does not know how to give explicit directions for the proper carrying out of this or that measure. It is this information which is to be found in Pusey's "Care of the Skin and Hair," which is a treatise on the hygiene of the hair and skin, written in a more or less popular style, and can be read by the doctor or layman alike with benefit.

RESOLUTIONS PASSED AT THE MARCH AND JUNE, 1912, MEETINGS OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION.

ADVERTISING BY UNJUST CRITICISMS OF THE MEMBERS OF THE MEDICAL PROFESSION AND BY THE REPORTING OF SURGICAL OPERATIONS IN THE NEWSPAPERS.

OWING to the increased tendency upon the part of some members of the medical profession, members and non-members of the different medical societies of the United States, to criticise, denounce and belittle other members of the medical profession who may not have had the opportunities for special clinical work and instruction in large hospitals, and the instruction and medical study and advancement obtainable only by a residence in a large city, in an unjust, unkind and uncharitable manner, which criticism we consider a detestable method of self-advertising, and without question the cause of increasing, directly and indirectly, the number of malpractice suits against physicians and surgeons—

Resolved, That the Baltimore County Medical Association at its regular monthly meeting held at Towson, Md., March 20, 1912, hereby petition and urge the Board of Councillors of the Medical and Chirurgical Faculty of Maryland to take such measures as it may deem best to suppress in the State of Maryland such methods as pernicious and disastrous to the medical profession, suspending or expelling all members who persist in such practice.

Also that a copy of these resolutions, signed by our president and corresponding secretary, be sent to the secretary of the Medical and Chirurgical Faculty of Maryland, with the request that they be laid before the Board of Councillors at its next meeting for its early action.

The members of the Baltimore County Medical Association have viewed with surprise and apprehension the increased frequency during the past two years with which a few of the prominent physicians and surgeons of Baltimore city have allowed—intentionally or otherwise, we do not know; the result, however, has been the same—the reporting in the daily newspapers the names of their patients, the name of the disease requiring the surgical operation or the medical treatment at their hands.

These self-advertising surgeons and physicians we have, in the past, held in the highest esteem and placed implicit confidence in them, seeking their advice and assistance as medical men.

Our protesting as individual members of the medical profession against the unprofessional and unethical methods by commercial advertising has had no influence to diminish the number of opera-

tions with the names of the attending physicians or surgeons reported in the daily newspapers; therefore, be it

Resolved, That the Baltimore County Medical Association at its monthly meeting held at Towson June 19, 1912, realizing that the high standing of the medical profession has been lowered in Maryland by the sins of omission or of commission of some of the surgeons and physicians of Baltimore who have allowed their patients' names, the names of the diseases for which medical treatment or surgical operations have been resorted to, and the name of the physician or surgeon in attendance, and the name of the hospital to which the patient has been taken, to be published in the daily press, this being a violation of the Hippocratic oath. That part particularly referred to reads: "Whatever in connection with my professional practice, or not in connection with it, I see or hear in the life of men which ought not to be spoken of abroad I will not divulge;" and, further, that such disregard for medical ethics is a gross violation of the code of medical ethics of the American Medical Association, of which we are a component part—the door of entry to the national association which we have been particularly charged to guard against the entrance of the unfaithful and the unprepared.

Resolved, That we hereby renew our allegiance to the American Medical Association, and again endorse and subscribe to the code of ethics as outlined by that association.

Resolved, further, That as the surgeons and physicians above described have, in our opinion, violated the code of ethics of the medical profession, we hereby pledge ourselves not to consult with nor allow them to operate on the patients we attend until such times as they shall purge themselves of the medical sin of self-advertising in the public press and have shown a willingness to comply with and be governed by the code of ethics of the American Medical Association.

Resolved, further, That it shall be the duty of any member of the Baltimore County Medical Association, knowing of a violation of the code of ethics of the American Medical Association by a member of the medical profession in Baltimore county or in Baltimore city, to notify the board of censors of the Baltimore County Medical Association in writing of such violation. It shall be the duty of the board of censors of the Baltimore County Medical Association to investigate the charge, and if found correct to submit a written report to the Baltimore County Medical Association at its next regular meeting, and upon vote of its members the name of the offender or offenders shall be placed on a list to be known as "The List," whereby the members of the Baltimore County Medical Association pledge themselves not to consult with such offender or offenders until the name or names be taken from said list.

Resolved, further, That a copy of these resolutions, signed by our president and our secretary, be sent to the secretary of each

of the medical societies or organizations listed in the Medical and Chirurgical Faculty Bulletin, with a request that they be read at the next meeting of the society to which the letter has been addressed.

Resolved, further, That a copy of these resolutions, signed by our president and our secretary, be sent to the secretary of the Medical and Chirurgical Faculty of Maryland, with a request that they be read before the Board of Councillors of that Faculty at its next meeting.

Resolved, further, That these resolutions are subscribed to in good faith. Our desire and our effort is to preserve the high standing and support the code of ethics of the regular medical profession now and always.

Book Reviews.

THE SURGICAL CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO. June, 1912. Published bimonthly. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Six numbers a year. Paper per year, \$8.

The reviewer cannot urge too insistently the acquisition of the sort of publication as the above. Here the reader obtains at first hand the practical experience of the writer, and not a collection of extracts from the writings of others. As in the other publications of John B. Murphy, so in this is the last word and best surgical thought and treatment on a variety of surgical subjects, pre-eminently among which are sections on the treatment of fractures, cholelithiasis, kidney, typhoid spine, extradural hemorrhage from trauma, and five diagnostic methods of John B. Murphy. The scope of Dr. Murphy's surgical knowledge is perhaps surpassed by no American—indeed, by anyone; therefore the American profession is fortunate to obtain in printed, permanent form the substance of his work as performed at his clinic in the Mercy Hospital.

BACKBONE—HINTS FOR THE PREVENTION OF JELLY-SPINE CURVATURE AND MENTAL SQUINT: A STRAIGHT-UP ANTIDOTE FOR THE BLUES AND A STRAIGHT-AHEAD SURE CURE FOR GROUCH. Collected from Various Sources and Arranged and Published by S. DeWitt Clough, Ravenswood, Chicago. Copyright, 1911. Fourth edition. Art binding, 50 cents; limp leather, \$1. Discounts for quantities.

We pick up the little book and lay it down with a smirk; then somehow we invariably pick it up again and lose the smirk while we read. You can read all day and not tire, or you can be so very tired, and pick it up and read a line, or perhaps four, and go on feeling better for your day's work. It is simply a collection of the short, pithy, attractive little sayings and poems that men like.

You like to have it in your desk, you like to have it in your pocket. It contains enough of philosophy to comfort a present-day Job; enough of wisdom to make a Rockefeller of a beggar did he but follow its teachings; enough of merriment to hold a vaudeville audience, and enough of energy to make the slowest and most indifferent straggler move a pace or two more swiftly for having read. Its prescriptions are all Christian Science ones, and its cures all of the mind; but it is worth while. To the man who would rest on his laurels it preaches, "Don't be too contented! However pleasant your surroundings, however placid your relations with your fellows, however self-satisfying your opinions, don't let them put you to sleep!" Watts, Thomas Browne, Elbert Hubbard, Kingsley, Harte, Van Dyke and a hundred others speak in its pages, and it is strange how each one arrives at the same conclusion and through so different a method. Get a copy and read it all, or read a snatch or two, and you will feel like "playing the game with the cards you have, and not asking for a new deal, but playing your game."

INFANT FEEDING. By Clifford G. Grulee, R.M., M.D., Assistant Professor of Pediatrics at Rush Medical College (in affiliation with the University of Chicago); Attending Pediatrician to Cook County, Provident and St. Bernard's Hospitals, and the Home for Destitute Crippled Children, Chicago; Associate Pediatrician to the Presbyterian Hospital, Chicago. Octavo of 295 pages; illustrated, some in colors. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1912. Cloth; \$3 net.

Infant feeding is taken up from every angle (practical and scientific), as can be seen by a glance at a catalogue of the contents—special points in the anatomy of the gastro-intestinal tract of the infant, physiology of the gastro-intestinal tract in the infant, absorption and metabolism, bacteriology of the gastro-intestinal tract of the healthy infant, attributes of the normal child, the human breast and breast milk, technique of breast feeding of the normal infant, nutritional disturbances in the breast-fed infant, foods used in artificial feeding, artificial feeding for the normal infant, general consideration of nutritional disturbances of the artificially-fed infant, weight disturbance, dyspepsia, decomposition, intoxication, symptoms and their causes, the premature infant, the exudative diathesis, the spasmophilic diathesis, the nervous infant, infant feeding in rickets, infantile scurvy, infant feeding in eczema, congenital pyloric stenosis and pylorospasm, infant feeding in other diseases.

More and more, both in the adult and infant, is it coming to be recognized that many of the ills of mankind are due to improper metabolism. Today the journals and medical books are filled with articles along these lines,

When one realizes that it was as recent as 1905 that Czerzy and

Keller first called attention to rational feeding of the infant along scientific lines, one only grasps the strides which have been made in this department of therapeutics. Not that attempts had not been made to evolve systematic methods of feeding infants, but the efforts had only been spasmodic and fragmentary. Since 1905 great strides have been made in our conception of feeding the young, as a consequence of which the infant mortality has been materially reduced. Only a short time back one-fourth of all deaths occurred in the first year of life, and of these about 60 per cent. were due to gastro-intestinal disturbances. The knowledge obtained of proper feeding during infancy alone has enabled this reduction in mortality. With these facts staring us in the face, it behooves every general practitioner to eagerly grasp every little hint which will enable him to better handle this group of affections. The education of the parents along these lines, as well as the profession in general, has been a potent influence in lessening baby mortality. Success in medicine in whatever line depends upon the physicians gaining the confidence and respect of the public. Without this trust in the profession by the laity nothing can be accomplished. Even the most ignorant have been brought by the agitation of the various pure-milk commissions to see the importance of properly feeding their offspring and implicitly following their physician's orders, whereby the world has been privileged to witness an extraordinary decrease in gastro-intestinal maladies in children—a cogent triumph of preventative medicine. It is with these advances that the above volume deals, the methods by which they have been brought about, and how to accomplish like results. While scientific feeding is the keynote, the practical aspect is not lost sight of, and feeding, including the procuring of the food, its preparation, handling, physiological and abnormal changes in the body, etc., is fully discussed. Feeding in all of its complexities in health and disease is so efficiently treated as to meet the approbation of the most critical. The author has produced a book well worth while, and it is a pleasure to recommend it to the profession.

PELLAGRA: HISTORY, DISTRIBUTION, DIAGNOSIS, PROGNOSIS, TREATMENT, ETIOLOGY. By Stewart R. Roberts, S.M., M.D., Associate Professor of the Principles and Practice of Medicine, Atlanta College of Physicians and Surgeons, Atlanta, Ga.; Physician to the Wesley Memorial Hospital; Formerly Professor of Biology in Emory College. With 89 special engravings and colored frontispiece. St. Louis: C. V. Mosby Company. 1912. Cloth; \$2.50 net.

Pellagra has become so widespread throughout the United States that any literature upon the subject should indeed be welcome to the medical profession. The above statement applies with especial force to Roberts' contribution, as it is especially meritorious. Every page shows a wide grasp of the subject by the author,

who discusses pellagra in its every aspect, history, distribution, diagnosis, prognosis, etiology and treatment. The contents contain the essential facts of pellagra, and are within reasonable bounds, which characteristic should render the book especially desirable to students and practitioners in general. Dr. Roberts expresses the opinion that pellagra is not contagious, and adduces several reasons for this belief, among which may be mentioned that no instance of the development of pellagra has been reported in the donor even after an hour contact of his vein to that of the pellagrin's. He states that more women than men are affected, and mentions this as one of the striking traits of the disease, but can give no adequate explanation of the same. Though not any startling new matter is added to pellagrous literature in the pages, still some consolation may be derived from the statement that pellagra is not an entirely hopeless disease, the author stating that treatment is of avail, especially when careful medicinal, hygienic and dietetic measures are employed. Although no specific has as yet been uncovered, the writer recommends arsenic as the best medicinal agent in combating the malady. It is given in full doses and is well tolerated by the pellagrin. Salvarsan used intravenously has, in the hands of King and Crowell in a series of 19 cases, been followed in each instance by improvement in the condition of the patient. As these injections were all made in 1911, it is as yet too soon to state definitely whether the improvement is temporary or permanent. Though Roberts gives the many theories as regards the etiologic factor of pellagra, he leaves the reader to draw his own conclusions, as there are objections to every one so far cited.

MATERIA MEDICA AND THERAPEUTICS, INCLUDING PHARMACY AND PHARMACOLOGY. By Reynold Webb Wilcox, M.A., M.D., LL.D., Professor of Medicine (Retired) at the New York Post-Graduate Medical School and Hospital; Consulting Physician to St. Mark's and to the Nassau Hospitals; President of the Society of Medical Jurisprudence; Ex-President of the American Therapeutic Society and of the Harvard Medical Society; Fellow of the American Academy of Medicine; Honorary Member of the Connecticut State Medical Society; Formerly Vice-President of the Revision Committee of the United States Pharmacopeia, etc. Eighth edition. Revised and enlarged. With index of Symptoms and Diseases. Philadelphia: P. Blakiston's Son & Co. Cloth. \$3 net. 1912.

What is better testimony that Wilcox's "Materia Medica and Therapeutics" has met the needs of the medical student throughout the country than the appearance of another edition, the eighth. Owing to the amount of new material, necessitated by recent advances, the present edition is divided into two parts.

the first dealing with *materia medica* and pharmacy; the second, pharmacology and therapeutics. In the section on *materia medica* space is devoted to pharmaceutical processes, the various kinds of preparations, with their dosage, prescription writing and a detailed description of the therapeutic agents. In this department the remedies are divided into groupings, according to whether they are organic or inorganic substances. In the division devoted to therapeutics the agents are brought together into groups according to the systems upon which the drugs act. The above arrangement is ideal, for it acquaints the student first with the remedies themselves, independent of their physiological actions, thus compelling of necessity the acquirement of a broader insight into the subject. There is no reason why the present edition should not prove as popular as any of its predecessors. In our judgment, the changes incorporated have simplified the treatise, and should increase its field of usefulness.

COLLECTED PAPERS BY THE STAFF OF ST. MARY'S HOSPITAL (MAYO CLINIC), ROCHESTER, MINN., FOR 1911. Octavo of 603 pages. Illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1912. Cloth, \$5.50 net.

The present volume contains all of the papers read by the staff of St. Mary's Hospital before medical societies, whether they have or have not appeared in medical journals.

Only after a careful inquisition of the present volume does the magnitude and the character of the work carried on at the Mayo Clinic begin to dawn upon the reader. The work being done is indeed unique. Here, entirely dissociated from any institution of learning, practical and theoretical surgical problems are being solved, surgical technique perfected and diagnostic methods evolved. By far the greater number of papers are on affections of the alimentary canal, genito-urinary organs and ductless glands, but they cover a wide range of activity. Of especial interest are the papers on ulcer and cancer of the stomach and intestinal canal, and the surgical treatment of gall-stone disease. From October 1, 1897, to November 1, 1911, 1264 cases of carcinomata of the gastro-intestinal tract were operated on at the St. Mary's Hospital, of which 863 involved the stomach, 14 the small intestine, 219 the large intestine and 168 the rectum. In the total number of carcinomata of the stomach it was possible to do the radical operation in only 307, or 35.5 per cent. In carcinoma of the small intestine five, or 35.7 per cent., were subjected to radical operation, and in the large intestine and rectum nearly 75 per cent. were operated on radically. These data would indicate that the stomach is the most frequent portion of the gastro-intestinal canal attacked by cancer, and that in only one-third of the victims is the disease recognized sufficiently early to offer the patient any pros-

pect of cure by surgical intervention. One is naturally impressed by the statement that of those cases of cancer of the stomach operated upon radically more than 23 per cent. are well after five years, 50 per cent. of patients submitted to radical operation for cancer of the large intestine, and 30 per cent. with cancer of the rectum who recovered from operation and whom could be traced are alive and well over five years. Dr. Mayo draws from these statistics that carcinoma of the gastro-intestinal canal which are sufficiently localized to justify radical operation give results fully as good as carcinomata in other parts of the body. Under which circumstances he cannot condone the pessimism of the medical profession regarding malignant disease of the gastro-intestinal tract.

The paper, " 'Innocent' Gall-Stones a Myth," should be read by every practitioner of medicine. The custom has been to teach that gall-stones existed oftentimes without giving rise to symptoms, which condition it was customary to speak of as innocent gall-stones. Dr. Mayo is firmly convinced these stones did cause symptoms, and that the physicians as diagnosticians, and not the gall-stones, were innocent. Mayo does not agree with those who state that 10 per cent. of all adults carry biliary calculi, but thinks 5 to 8 per cent. in women and 2 to 4 per cent. in men would be more near the truth. He concedes that gall-stones may be present without symptoms recognizable as coming from gall-stones, with the following qualification, however, that when gall-stones are met with accidentally during an operation for other causes, and the history is retaken in the light of these findings, it will usually be found that symptoms were present, but were not differentiated from the symptoms of the disease for which the original operation was undertaken. He subscribes to the hypothesis of Lartigau concerning the bacterial causation of gall-stones, and agrees with the modern conception of the colon and allied groups as being the principal bacterial agents, especially the bacillus typhosi. Rather than to an ascending infection through the common duct, he is inclined to the belief that the invasion of the gall-bladder is rather by way of the portal vein through the liver to the biliary bladder. According to his observations, gall-stones are more frequent in women than in men. In 4000 operations which his brother (C. H.) and he have performed on the gall-bladder and biliary passages 3075 were in women and 925 in men.

The staff of St. Mary's Hospital have operated on but three male patients for gall-stones who were under 20 years of age, against 38 females. According to his statistics, 90 per cent. of married women who have gall-stones have borne children, and 90 per cent. of these women identify the beginning of the symptoms with some particular pregnancy. He notes that quiescent stones often become active during pregnancy, and in a number of instances, owing to rapidly recurring colics, obstruction with infection or to remove stones which have been forced down into the common duct, operation became imperative. Recovery was always speedy, and in no case did the operation cause the spontaneous

termination of the pregnancy. Complications of one sort or another were found in more than two-thirds of the patients on whom gall-stone operations were performed. The most serious of which is carcinoma of the gall-bladder. He states that in cases in which the carcinomatous condition of the gall-bladder was sufficiently advanced to diagnose at the time of operation, the patients did not survive one year, but in a number of instances an early carcinoma was removed accidentally, so to speak, in removing thick-walled, functionless gall-bladders, and five of these patients are well and alive at periods of from two to six years after operation. He pertinently asks, as gall-stones are foreign bodies, why delay operating until complications occur? In his experience, simple operation for uncomplicated gall-stones has a mortality of less than 0.5 per cent.

Consequently, any who are unable to visit the Mayo Clinic are now able to obtain at firsthand the technic as evolved at St. Mary's Hospital, Rochester, Minn. In conjunction with the volumes previously published, the symptomatology, pathology, diagnosis, prognosis and operative technic of cancer of the stomach, ulcer of the stomach, omental and other forms of hernia, thyroid gland affections, varicose veins, renal troubles, intestinal diseases, etc., as formulated from an enormous amount of material are herein depicted. In days of yore the pathology of abdominal surgical maladies was terminal in character; therefore, many of the deductions of the dead house were erroneous. The Mayos early realized that pathological changes of this character were not to be relied upon by the operating surgeon, and from the beginning of their careers they have faithfully set forth the pathology of surgical diseases in their incipency, thereby completely changing not only the pathological picture, but also the clinical and the prognosis. It is useless to iterate their conclusion that cancer of the stomach is in at least 60 per cent. of its incidence engrafted on an old ulcer. A further conclusion naturally follows that the occurrence of that cancer is to be decreased only by early recognition of ulcer and the institution of appropriate treatment, namely, excision of the ulcer-bearing area. Even those not interested in the practice of surgery will find in these volumes a mass of information of use to them as practitioners of medicine, for, after all, it is the clinicians who in most instances first see the patients suffering with surgical troubles, and the surgeon is of necessity forced to rely upon the internist for an early reference of cases belonging within the realms of surgery. As no surgeons in America—perhaps in the world—have had such an abundance of material from which to base deductions, the above volume, a masterpiece of clinical observation, should prove of inestimable value in their daily work.

It is impossible with the space at our command to fully describe all of the good features of the volume. Suffice it to say that every

American physician should have at first hand an account of the yearly work being carried on at Rochester, Minn.

AN ESSAY ON HASHEESH. Including Observations and Experiments. By Victor Robinson, Contributing Editor *Medical Review of Reviews*; Pharmaceutical Chemist, Columbia University; Member of the American Chemical Society; Author of "Pathfinders in Medicine." 1912. New York: *Medical Review of Reviews*. Cloth; 50 cents.

In this monograph Victor Robinson has studied cannabis indica from the historical, chemical, botanical, physiological, psychological, therapeutic and pharmacological standpoints. Zest is added to his findings by his having personally partaken of the drug in order to be able to faithfully portray its effects upon the human body. Besides the experiments upon himself, he prevailed upon some of his friends to take the drug also and to make observation of its actions upon them. Through these experiments upon himself and others the author has been enabled to produce a most interesting as well as instructive little book, and to set forth succinctly and entertainingly the physiological actions of the drug under discussion.

GOULD AND PYLE'S CYCLOPEDIA OF PRACTICAL MEDICINE AND SURGERY. With Particular Reference to Diagnosis and Treatment. Second edition, revised and enlarged. In two volumes. By R. J. E. Scott, M.A., B.C.L., M.D., New York. With 653 illustrations. Philadelphia: P. Blakiston's Son & Co. 1912. Cloth; \$14 net.

The above books will be found by the general practitioner to meet many unexpected demands and to fill a place which no other book or set of books in his library can supply, as these two volumes cover the medical field in its entirety, and though concisely, yet accurately and authoritatively. It is this feature which should appeal to the general practitioner, for the editor, Dr. Scott, has enlisted in his service the cream of American specialists, who have contributed the sections dealing with their specialties. The arrangement of the subject-matter is ideal. The first subject discussed commences with the first letter of the alphabet, and the method is continued on in this wise through Z. This style renders the finding of any subject by the reader exceptionally easy, and as there is an elaborate cross-reference, no general index is required, this feature enabling more space to be devoted to actual reading matter. Both volumes are well illustrated, which attribute adds distinctly to their attractiveness as well as utility. The work is in every sense thorough, and the keynote is practicalness, which qualities should commend it to the practitioner, who will find in it a friend when in need and when in a hurry to place his hands upon the latest thought on any medical subject.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor*.

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BALTIMORE, OCTOBER, 1912

WORRY, A CAUSE OF ARTERIOSCLEROSIS.

ARTERIOSCLEROSIS is so prevalent and of so great a consequence to the happiness and welfare of the human family that any contribution which throws a ray of light on its etiology is worthy of the deepest consideration of the profession. To date almost every conceivable agent has at one time or other been ascribed as the cause of hardened arteries. Syphilis, overeating, gout, alcoholism, rheumatism, nephritis, excess in the use of tobacco, infection, toxemia, etc., have one and all been accused of an important part in its causation. Clapp, in the *Medical Record* of September 21, 1912, adds to this list worry, which he is inclined to believe should be accorded a prominent place among the causative factors—indeed, a much more prominent position than some of the above. He has met with cases in which all of the above causes, with the exception of worry, could be entirely eliminated, thereby leading to the conclusion that worry, at any rate in these instances, was the sole and only cause of the arterial changes. He further states that the recognition of worry as a cause would relieve the profession of the suspicion of casting reflection on a person's character—a very important aid in gaining the confidence of the patient. He is of the opinion that the time has come to counteract the common belief among the profession that arteriosclerosis is always the penalty of some earlier indiscretion, for absolutely upright and moral men may be afflicted with the affection. Great harm will result, he says, if this idea becomes as prevalent among the laity as it is now among a portion of the medical profession. As to the causation of some diseases, a snap judgment without knowing anything about the particulars of the case is justifiable. For instance, so large a majority of the men who are afflicted with locomotor ataxia have previously had syphilis that the conclusion that practically every case is due to lues is justifiable, and is in all probability not far from the truth. This method of deduction is not, in his opinion, applicable in arteriosclerosis. Its causes are so various, so indefinite, and often so composite, that a random opinion is entirely out of place.

While the conclusion of Clapp may be inaccurate, the wide prevalence of hard vessels and the important part it plays in the incapacitation of the race, as well as its prominence as a death factor, demands the most painstaking and careful attention of the profession in its control and elimination. It is now a well-recognized fact that hard arteries, which necessarily includes heart and kidney affection—for they all go hand in hand—demand a greater yearly toll than either cancer or tuberculosis.

Clapp states that, after syphilis, overeating is the most prolific cause of hardened arteries, and recommends that the temperance societies should consider the advisability of making an important part of their campaign against overeating as well as against drinking. This overfilling of the human furnace with more fuel than it can thoroughly burn up, if sufficiently prolonged, is bound to leave its effects upon the walls of the arteries sooner or later, perhaps only after the lapse of years. As the interval is sometimes so long, the resulting hardening is not infrequently considered as one of the customary and proper accompaniments of old age, like the natural process of decay of leaves in the fall. Clapp is of the opinion that this is not true, there being many reasons to believe that a perfectly proper and hygienic life in every sense would not be followed by arteriosclerosis. The writer reasons that if excessive muscular strain, long continued, by contracting the superficial vessels, is able to increase the blood pressure, thereby producing arterial changes, excessive mental work may in a like manner lead to arterial degeneration. Admitting worry as a potent influence in the causation of hard arteries, Clapp pertinently asks, "If we find anybody worrying unduly, what shall we do about it?" Simply telling him not to do so will do about as much good as trying to keep the sun from shining. The case has to be handled with tact and the folly of worrying impressed upon the patient. Other than this advice, he gives us no aid in rectifying or correcting the condition. He says that it is a bad habit, and that most of our worries are about things which have never happened, and consequently should be given up. This is good advice, but does not help us out of the difficulty. Nevertheless, we thoroughly believe him to be right when he ascribes worry as a powerful influence in the production of arteriosclerosis, acting through the perversion of the bodily functions which are associated with it, and should always be borne in mind as a possible cause when treating arteriosclerotics.

Medical Items.

DR. WILLIAM SIMON has purchased a cottage at Eaglesmere Park, Pa., which he will use as a summer home.

DR. NATHAN WINSLOW has returned from a visit to St. Augustine and Jacksonville, Fla., and Savannah, Ga.

DR. WILLIAM J. COLEMAN, superintendent of the University Hospital, spent some time in Norwich, Conn., and enjoyed a motor trip through the Berkshire Hills. During his absence Dr. FitzRandolph Winslow served as acting superintendent of the hospital.

THE marriage of Miss Florence Brush, daughter of Dr. Edward N. Brush of Towson, to Dr. Lloyd Parker Shippen, Johns Hopkins Medical School, of Baltimore, will take place at Towson October 2, 1912.

DR. LOUIS R. PALMER, of 1021 Madison avenue, is reported as being seriously ill with stomach trouble in a hospital in Philadelphia, Pa., where he had gone on a short vacation.

DR. JOHN T. MCCARTHY, 656 W. Franklin street, has been suffering with a nervous breakdown, but is now much improved.

DR. RUSSELL DEAN, of the class of 1912 of the University of Maryland, and a native of Jacksonville, Fla., is in the mountains of North Carolina because of ill-health.

DR. MONTE GRIFFITH of Washington has been ill at his home for about two months.

THE Board of Regents of the University of Maryland at a meeting held September 25, 1912, decided to appoint a special committee of one member from each department of the University to consider the question of the appointment of a president. Unusually broad powers will be vested in the committee, which will consider what changes, if any, are to be made in the University's charter, and whether or not a salaried president is to be chosen.

DR. FRANCIS E. HARRINGTON was seriously burned by the explosion of a gas tank in the laboratory of the Cumberland City Hall on September 16.

DR. EDWIN V. WHITAKER, University of Maryland, '12, was appointed assistant superintendent of Sydenham Hospital to succeed Dr. Sidney Wallenstein, resigned. Dr. Whitaker is a native of Baton Rouge, La., and attended the University of Louisville before coming to Baltimore.

DR. J. E. FITZNOGLE has resigned as health officer of Washington county.

MISS HELEN KELLER, in a speech before the Otologists' Congress in Boston, paid the following tribute to the late Dr. Julian J. Chisolm: "I was about six years old before any of the specialists my parents consulted was brave enough to tell them that I should never see or hear. It was Dr. Chisolm of Baltimore who told them my true condition. 'But,' said he, 'she can be educated,' and he advised my father to take me to Washington and consult Dr. Alexander Graham Bell as to the best method of having me taught. Dr. Chisolm did exactly the right thing. My father followed his advice, and within a month I had a teacher and my education was begun. From that intelligent doctor's office I passed from darkness to light, from isolation to friendship, companionship, knowledge. The parent who brings his child to your office, to your hospitals, should find in you not a teacher, perhaps, but one who understands how far it is possible to right the disaster of deafness."

THE future of the Maryland Medical College is now being discussed, and it is probable that some action will be taken during the coming month.

DR. W. DEFOREST OLMSTEAD was operated on at the Maryland General Hospital for appendicitis on September 14, 1912.

DR. J. H. MASON KNOX, JR., of Baltimore, will present a paper entitled "The Effect of Atmospheric Temperature on Infants" at the third annual meeting of the American Association for the Study and Prevention of Infant Mortality, to be held in Cleveland October 2 to 5.

DR. WILLIAM ROYAL STOKES has sufficiently recovered from his recent indisposition to resume his duties as city bacteriologist.

THE South Baltimore Hospital is trying to raise funds for the purchase of an additional hospital building, and the board of managers of

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BALTIMORE, MD.

the Eastern Shore Hospital for Indigent Insane have decided to borrow \$8000 for the purchase of land for the hospital.

DR. WILLIAM TARUM has been obliged to give up his practice and go to the Adirondacks because of ill-health.

THERE have been many cases of typhoid fever reported in the vicinity of Towson, but it is stated that the disease is now under control.

DR. THOMAS R. BROWN has accepted a position in the Ohio State Hygienic Laboratory, Columbus, Ohio, and has charge of the bacteriological and research departments.

THE Colonial Dames have endowed a room at the Hospital for the Women of Maryland, to be known as the Margaret Brent Room.

DRS. J. T. SAMPLE AND R. H. MAJOR have sailed for Europe.

THE Harriett Lane Home for Children, Johns Hopkins Hospital, will be opened October 1. Dr. John Howland will be in charge.

MARRIAGES.

JAMES HUGH BAY, M.D., University of Maryland, '08, of Havre de Grace, Md., to Miss Mary Barton Saulsbury of Govans, Md., at Govans, September 10, 1912.

GEORGE WILMER YOURTREE, M.D., University of Maryland, '02, to Miss Laura Eleanor Hightman, both of Burkittsville, Md., at Burkittsville, September 25, 1912.

A. MONTALVO GUENARD, M.D., Baltimore Medical College, 1912, of San Juan, Porto Rico, to Miss Mae Carroll of Baltimore, Md., at Elliott City, Md., June 26, 1912.

FRED YOHN CRONK, M.D., Johns Hopkins Medical School, '07, of Guthrie, Okla., to Miss Mildred A. Myers of Baltimore, at Pen-Mar, Md., September 14, 1912.

MAURICE EUBANKS BROADUS OWENS, M.D., University of Maryland, '10, of Long Lake, Washington, to Miss Maysville Jane Freeman of Baltimore, at Spokane, Washington, September 1, 1912.

CHARLES CHAUNCEY WINSOR JUDD, M.D., Johns Hopkins Medical School, '11, to Miss Mildred

Rife, both of Baltimore, September 21, 1912, at Baltimore.

HOWARD J. MALDEIS, M.D., University of Maryland, '03, of Baltimore, to Miss Louise Cecil Watkins of Arlington, Baltimore, at Arlington, September 7, 1912.

DEATHS.

ELIZABETH HEDGES BLAUVELT, M.D., Johns Hopkins Medical School, '02, died at Saranac Lake, N. Y., September 1, 1912, from tuberculosis, aged 30 years.

THADDEUS LINDLEY ROBERTSON, M.D., Jefferson Medical College, '61, died at his home in Birmingham, Ala., August 16, 1912, aged 76 years.

JAMES H. BUTLER, M.S., University of Maryland, '57, was stricken with apoplexy while seated at luncheon in his home on September 27, 1912 and died almost instantly. Dr. Butler was 75 years of age.

HENRY STRONG DENISON, M.D., Johns Hopkins Medical School, '08, died at his home in Denver, Colo., August 24, 1912, from the effects of bichlorid of mercury accidentally self-administered, aged 29 years.

WILLIAM HORACE JOHNSON, M.D., College of Physicians and Surgeons, '79, died at his home in Dudley, Pa., August 17, 1912, aged 70 years.

CHARLES F. HOPKINS, M.D., College of Physicians and Surgeons, '84, died at his home in Long Beach, Cal., August 18, 1912, from cerebral hemorrhage, aged 53.

ABEL HUSTON THAYER, M.D., University of Maryland, '76, died at his home in Grafton, W. Va., September 8, 1912, aged 70 years.

ROBERT M. DAWSON, M.D., University of Maryland, '69, died at his home in Sherwood, Md., September 8, aged 73 years.

CHARLES HENRY BRUECKNER, M.D., College of Physicians and Surgeons, '01, died at his home in Newark, N. J., June 24, 1912, from peritonitis, aged 36 years.

HORACE H. WOLFF, M.D., Baltimore Medical College, died at his home in Providence, R. I., in August, aged 47 years.

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SOME LARYNGOSCOPIC, BRONCHOSCOPIC AND ESOPHAGOSCOPIC CASES.

By Richard H. Johnston, M.D.,
Baltimore, Md.

IN January, 1912, I was asked by Dr. R. A. Warner to see a little girl, two years old, at the Municipal Hospital for Infectious Diseases. The history, in brief, was that she had worn an intubation tube five days during an attack of diphtheria. After the removal of the tube and during convalescence she developed difficulty in breathing, which grew gradually worse. When I saw her the breathing was stridulous, with cyanosis on exertion. The examination of the larynx was made without anesthesia, with the head held straight on the table, the instrument used being the Jackson small laryngoscope. When the larynx was exposed, one could see in the subglottic space a swelling of the left wall almost closing the lumen. It was thought best to intubate with a one-year tube and to transfer the child to the Presbyterian Hospital for further treatment. That afternoon, in a fit of coughing, the tube was expelled. I then attempted to pass a two-year tube, but it would not go, so the one-year tube was replaced. That night the tube was expelled the second time, and the child's condition became rapidly worse, so that I had to do a tracheotomy. The little patient rallied promptly, and a few days later I was able to adjust Rogers' apparatus for stenosis of the larynx, which consists of an intubation tube held in the larynx by a grasping forceps introduced through the tracheotomy wound, which clamps the tube, and which, in turn, is held in place by a hard-rubber piece screwed on the handles. This was removed from time to time and the larynx inspected through the direct laryngoscope. In four months' time the apparatus was permanently removed and the wound in the neck allowed to close. At the present writing the patient is well, with normal voice.

In April, 1912, Dr. J. W. Murphy of Wilmington, N. C., referred to me A. W. B., 27 years old. In July, 1911, he had a severe attack of typhoid fever, which during convalescence was complicated by a gradually increasing dyspnea, which finally required tracheotomy. When I saw him he was wearing the tracheal canula and his voice was only a hoarse whisper. Examination through the direct laryngoscope under local anesthesia showed the

larynx completely closed except behind where an opening allowed the passage of a small probe. Breathing through the larynx was impossible. Through the direct laryngoscope, with a long knife, the cicatricial tissue was cut through from behind forward and intubation tubes, gradually increasing in size, forced through the opening. A few days later Rogers' apparatus was adjusted and the patient was allowed to return to his home in South Carolina to be treated by Dr. Murphy. He attends to his business as superintendent of a mill and is able to whisper.

In June, 1912, a deaf mute was referred to me by Dr. J. J. Carroll. Some time before, he fell and struck his larynx against a wheelbarrow, after which it was noticed that he could make no sound and that difficulty in breathing developed, which grew rapidly worse. An attempt was made to examine the larynx through the direct laryngoscope under local anesthesia, but on account of a chorea it was impossible. During the examination his breathing became so labored we decided to do a tracheotomy under local anesthesia, with the patient sitting. This was done and the tracheal tube introduced, after which breathing became quiet. A few days later the larynx was examined under ether, and almost complete stenosis found. Rogers' apparatus was adjusted and the patient sent home. He returned the middle of September, and upon removal of the tube we found the stenosis practically gone. A tracheal tube was introduced to see if the larynx would remain open. A few days later the patient pulled the tube out and the resident physician was unable to get it back. The larynx remained open and the patient was discharged.

In January, 1912, a little girl, two years old, was referred to me by Dr. J. J. Carroll. A week previously she had swallowed a nickel, which the X-ray showed at the upper end of the esophagus. The patient was sent to St. Joseph's Hospital for operation. That afternoon she was pinned in a sheet and placed on the table with the head straight and held by a nurse. Jackson's small tube was passed down behind the larynx and the upper end of the esophagus exposed. The foreign body immediately came into view, lying back of the middle line, with edges transverse. Bruening's extension forceps were passed through the tube, the coin seized and removed along with the tube and forceps. No anesthetic was used. The patient made an uneventful recovery.

In September, 1912, Dr. J. F. Hempel referred to me a man, aged 42 years, who had had increasing difficulty in swallowing for three months. When I saw him, by violent muscular contractions he could swallow a few drops of milk. Under ether the esophagoscope was passed and a firm stricture found about an inch below the cricoid cartilage. Bunt's smallest bougie was introduced through the tube and the stricture dilated. There were three distinct strictures. Larger bougies were then passed under the guidance of the eye. The next day the patient swallowed milk and raw eggs easily. Two days later a French bougie, No. 37, was passed

and the patient sent home. The stricture will be dilated every few days, and in a short time the patient will be swallowing everything.

In June, 1912, Dr. James Bordley referred to me a female, 60 years old, for a stubborn cough and intermittent expectoration of blood. She was well nourished. Nine months previously Dr. Bordley had removed the left eye for sarcoma of the ciliary body. Under local anesthesia the 9-mm. bronchoscope was readily passed. The mucous membrane of the trachea and upper bronchi showed nothing abnormal. In one of the right terminal bronchi at the beginning of a tertiary bronchus a fringelike bleeding mass could be seen. The growth resembled in appearance a papilloma. I had no forceps small and powerful enough to remove a piece for microscopic examination. It may be interesting to note that Dr. T. R. Boggs had previously diagnosed bronchial obstruction.

In July, 1912, a boy was brought to me from Crisfield, Md., with the diagnosis of a foreign body in the air passages. The temperature of 100° and a hoarse, croupy cough seemed to indicate that the diagnosis was correct. The boy was given ether the same morning, the 7-mm. bronchoscope was passed, and the foreign body—a grain of corn—removed from the right bronchus, in which it was tightly wedged. The grain was twice its original size, having been in the air passages four days. The patient made a good recovery, and three days later returned to his home.

A little girl, two years old, from Jacksonville was referred to me by Dr. Herbert Harlan with the history of having aspirated a watermelon seed two weeks previously. The patient was pinned in a sheet, placed on the table with the head straight. A 5-mm. tracheoscope was easily passed and the seed came into view. It was grasped with difficulty because it was slippery, but was finally removed. The patient made a good recovery.

A young lady had had a severe cough for four months following la grippe. She had taken all sorts of cough remedies without result. A bronchoscopic examination revealed a tracheitis, which was treated six times through the tube with nitrate of silver. After the last application I left the city on my vacation. On my return in September she called me up and told me that the last application had cured the cough.

In September, 1912, a physician brought his little girl, 19 months old, to me with the history of having swallowed a penny one week before. Thinking that the foreign body would pass through, he paid no special attention to it. The baby's continued difficulty in swallowing, however, led him to have X-ray pictures made, which showed the coin at the first dorsal vertebra. The little patient was taken to the University Hospital for treatment. After wrapping her in a sheet, she was placed on the table with the head straight. The small laryngoscope was passed and the coin located at the upper end of the esophagus. Jackson's forceps were introduced through the tube, the penny seized and quickly removed. Recovery was uneventful.

THE MEDICAL FATHERS OF BALTIMORE COUNTY, MARYLAND.

BIOGRAPHICAL SKETCH

OF

DR. JAMES HENRY JARRETT

TOWSON, MARYLAND

Read at the Unveiling of His Portrait Before the Baltimore
County Medical Association, October 16, 1912

By Dr. William J. Todd,
Mt. Washington, Md.

DR. JAMES HENRY JARRETT was born February 24, 1832, near what is now known as Taylor, Harford county, Maryland.

Our future doctor and soldier was born under a lucky star if we are to judge by the era in which he made his first appearance. To stand at the eightieth milestone on the great highway of life and retrospectively look over an active, well-spent life in the practice of the healing art, to have seen the awakening of medicine, to have witnessed the putting off of the old and the taking on and developing of the new, to note here an invention, there a discovery, here a means of alleviating pain, there a method of lengthening human life, well might he repeat with religious enthusiasm and devotion the first telegraphic message sent by Morse over the wire from Baltimore to Washington on May 1, 1844, "What hath God wrought!" (Numbers xxiii, 23.)

Andrew Jackson was serving his first term as President of the United States (1829-37) when young Jarrett was born. "The Jacksonian era, in the transformation it effected, was the most notable in the history of the country between the Revolution and the Civil War. That economic transformation was really the basis of the political transformation. Both had been made possible largely by mechanical inventions of the age. The first railroad had been built in 1830, and by 1840 there were 2,816 miles of such roads in operation, opening up distant lands for settlement. What the building of canals meant in economics may be realized from the statement that in 1820 it had cost \$88 to carry a ton of freight from Albany to Buffalo, while, after the canal got into complete operation, tolls fell to \$6.50 per ton.

To the year 1831 belongs the invention of the farmer's reaper. Inventions of all kinds, in fact, were numerous in those Jacksonian years—so numerous that in 1836 a patent office had to be created by the Government as a separate bureau. (Great Epochs in American History, Francis W. Halsey, Vol. 6, folio IX). Before the Patent Office was created the President of the United States gave the inventor a diploma setting forth his invention. We have an illustration of this in the diploma granted to Dr.

Horatio Gates Jamison. This diploma is now in the keeping of the Medical and Chirurgical Faculty of Maryland.

To have been born early enough to have been benefited by these great economic and political transformations, at a time when the transference of the control of the United States Government from the aristocratic influence to the democratic influence was consummated in the election and administration of Jackson; to have watched the development of the modes of travel from the farm wagon drawn by oxen to the horse cars on wooden rails, to be superseded by the locomotive pulling trains at 10 to 15 miles an hour; to watch the rapidity of travel go by leaps and bounds, from epoch to epoch, to the flier at 70 miles or more an hour; to have watched the horse develop from a "2.30 gait on a plank road" to be overtaken and outclassed by the electric car, bicycle and automobile; to have watched the desire for speed grow—to become a mania—when life in large commercial centers has become a mad desire upon getting up in the morning to see how much one can accomplish before bedtime and going to bed exhausted, only to do the same maddening act the next day, making a Titanic disaster of life; to have been an observer of all this, and to have been able to read the handwriting on the wall and profit thereby shows a well-balanced poise.

Dr. Jarrett's paternal grandfather, Jesse Jarrett, was of English descent; he was born in Harford county, Maryland, and was a successful farmer owning a large tract of land, extending from Taylor postoffice to the Pennsylvania State line. He had four sons, Abraham, Asbury, Jesse and Luther. Asbury was in the War of 1812 and later a prominent and successful merchant tailor at Baltimore and Front streets. Jesse followed the occupation of his father, remaining in Harford county. Luther M. Jarrett, the father of Dr. James H. Jarrett, was born in Harford county in 1804. On March 3, 1830, he married Miss Julia Anne Scarff, mother of the subject of our sketch. In 1837 he laid out the present town of Jarrettsville, which was named for him, and where he removed and established a successful business as a general storekeeper and farmer.

Luther M. Jarrett was prominent as a leader in the Democratic party in his county. He served two years as representative of his district in the Maryland Legislature. He held other positions of honor and trust. Dr. Jarrett's early life was spent on the farm and attending the country school. In 1848 he entered Dickinson College at Carlisle, Pa. He did not remain to take his degree. The president, Professor Emory, had just died. William H. Allen succeeded Dr. Emory, to be succeeded by Rev. Dr. Peck. Our student, Jarrett, after two years at Dickinson College, was given the option by his father of completing the literary course at that college and taking a degree, or of matriculating at the University of Maryland. The future doctor chose the last proposition, entering in 1850 the office of Dr. James Montgomery on Eutaw street.

near Mulberry street, where he remained under his preceptor's care until he graduated at the forty-fifth commencement of the University of Maryland in 1852. The commencement exercises were held in the Maryland Institute building on Marsh Market Space in April. The Hon. John F. Kennedy, LL.D., provost of the university, conferred the degrees of doctor of medicine, and the late Dr. G. W. Miltenberger addressed the graduating class. The class contained men who afterward made a success in life in their profession. I will name a few, you will recognize the names: Robert Barthelow, late of the Jefferson Medical College, Philadelphia; Hansom Mauer Drach, father of Dr. Drach, of Butler, Md.; George Gibson Farnandis; J. Perkins Fleming, father of Dr. G. A. Fleming; Henry T. Goldsborough; Buckler Jones; Thomas B. Owings, of Ellicott City, who retired from active practice last year.

Dr. Jarrett recalls that his graduating thesis was on pneumonia; that the college year commenced in October and ended in March; that two years' attendance upon lectures was required for graduation; that all examinations were verbal; that there were no clinics on obstetrics, and that for practical knowledge in this branch the young student depended upon the thoughtfulness and kindness of his preceptor; that the clinics were the patients brought before the class composed of first and second year men; that the symptoms were discussed and cases demonstrated in the amphitheater; that there were very few lectures on the diseases of children, very little attention being paid to these small patients. The medical care of the children at this time was given over to mothers and grandmothers. It was not until 1866 that the first child's clinic was formed, and in the following year the chair of diseases of women and children was established in the university. (*Medical Annals of Maryland*, Cordell, folio 708.)

After graduation Dr. Jarrett returned to his father's home to take up the practice of medicine, April 29, 1852. The same year, November 16, 1852, he married Julia Ann Horner Spotswood, daughter of William Spotswood, of Carlisle, Pa., who lived to be 69 years old.

On questions that led up to the Civil War Dr. Jarrett took the side of the North, much to the displeasure and opposition of all the members of his family. He enlisted in the Purnell Legion, organized by William H. Purnell, who, being appointed to the office of postmaster of Baltimore city, was unable, because of the duties of that position, to assume active charge of the legion. Dr. Jarrett enlisted as an assistant surgeon; after one year's service he was promoted to surgeon of the Seventh Maryland Infantry, organized and commanded by Col. E. H. Webster, of Harford county, an attache of the Army of the Potomac. The late Judge Phelps, a member of this regiment, was later placed in command when Colonel Webster was elected to Congress. His service was on the eastern shore of Virginia. At the headquarters of Captain

Duvall at Cherrystone, the guns of the Merrimac and the Monitor could be heard. Dr. Jarrett was present when the information of the battle was sent to Eastville by an orderly to be telegraphed to Washington.

Originally, Dr. Jarrett was a Whig; in 1855-6 he represented Harford county as such in the State Legislature. He was a member of the State Convention which nominated Thomas Holliday Hicks for Governor. In 1860 he voted with the Republican party and has voted that ticket ever since. Under President Arthur he was made a member of the United States pension examining board. Governor Lowndes appointed him one of a commission of three to compile and publish a record of the Union soldiers of Maryland during the Civil War. Dr. Jarrett was in Baltimore during the riot, April 19, 1861. He came from Harford county that morning on the Northern Central Railroad on business, and was in the neighborhood when the riot took place. He had to return to Harford county on a hay wagon the next day, the bridges of the Northern Central Railroad having been destroyed. In 1865 Dr. Jarrett located in Towson, where he had many warm friends and where he succeeded in building a large practice.

During Dr. Jarrett's long life he has seen many changes and advances in medicine. In 1850 laudable pus was called for and expected in all surgical operations. Union by first intention was a myth. Abdominal surgery was unknown. Antiseptic surgery was not dreamed of, although here and there were individuals making attempts to have clean wounds. Witness the attempts of Dr. Bode, of our own county, in the fifties; I read a sketch of his life to you last year. Dr. Jarrett lives to appreciate the work of Pasteur and Lord Lister in bringing about antiseptic surgery and antiseptic midwifery, with almost the total extinction of puerperal fever. In 1843 Holmes published his essay on "The Contagiousness of Puerperal Fever" (republished in 1855, Camac), but it was not appreciated by the profession until later years. Dr. Nathan R. Smith, "the Emperor," was in his prime at this time; and right here may I inquire of the hypercritics of the conditions of today where Dr. Nathan R. Smith would be if he were living today enjoying all our advancements? In the front ranks of the profession as he was in his day.

When Dr. Jarrett matriculated, Dr. Samuel Chew, the father of our Dr. Chew, was professor of materia medica. The development of this branch of medicine has not been behind surgery and obstetrics. Obstetrics in 1850 was a didactic branch. All the experience the student got at the medical colleges was from manikins. It was not until 1874 that the first maternite south of the Mason and Dixon Line was organized by the College of Physicians and Surgeons in Baltimore. In 1858 Dr. G. W. Miltenberger became professor of obstetrics. ("Medical Annals of Maryland," Cordell, folio 705.)

The microscope was not generally used in 1850, and was kept

as an ornament and a curiosity under a bell glass. Histology and embryology were not taught. Pathology was taught in the gross. It was in 1853 that the Baltimore Pathological Society was founded by Drs. Stewart, Pottinger, Frick, Murdock, Turner, Donaldson, Johnston, T. H. Buckler and Van Bibber. ("Medical Annals of Maryland," Cordell, folio 703.) Bacteriology was not taught, although Dr. John Crawford, one of the professors at the University of Maryland, who died in 1813, practiced medicine under the germ theory. Post-mortems were very few, if any. The use of the clinical thermometer had not been discovered, and the physician had to depend upon the pulse to have some idea of the degree of fever.

When Dr. Jarrett matriculated ether had been discovered and made use of as an anesthetic for the first time by Dr. Morton (1846), but, strange to say, chloroform was given the preference in Baltimore. The writer remembers distinctly when he matriculated chloroform was still the favored anesthetic in Baltimore. The theory of spontaneous generation, which was much in vogue a few years before Dr. Jarrett's graduation, was about discarded, and, strange as it may seem, Dr. Jarrett has lived to see this theory again revived. Phlebotomy, once the sheet anchor of medicine, was falling into disuse when Dr. Jarrett graduated, and has since been abandoned. Very few of the present generation of physicians have seen the operation performed. Dr. Jarrett remembers that immediately after graduating he was called to see a lady who was in a highly nervous condition; she insisted upon being bled. Dr. Jarrett assured her that she had no blood to spare, but she insisted, and he took about one-half a cup of blood from her, and she made a good recovery.

Hydrophobia was not fully understood and there was no special treatment for it until the discoveries of Pasteur. Pregnant negro mothers were cared for by negro midwives, physicians being called to assist only in difficult cases; these same midwives also cared for white mothers during confinement, except where the families were wealthy. The wealthy mothers were cared for by man midwives. Monthly nurses took care of the mother and infant, and in some cases managed the household at the same time.

In 1852 there was no special treatment for typhoid fever. Calomel and aperients were given; no cold water nor fresh air was allowed, windows being closed tight. The mortality of typhoid fever was about 20 per cent. to 25 per cent.

It was not until 1880 that Eberth discovered the bacillus typhosus. Dr. Jarrett has lived to see the development of the treatment of typhoid fever from the crude method as given above to the more successful method of today. For pneumonia all patients were bled; mustard plasters were used over the chest; no fresh air nor cold water was allowed; everything given to the patient was hot. The medical treatment was squills and ipecac. The mortality of pneumonia depended upon the amount and kind of

nursing the physician gave the patient, assisted by members of the family. It was not until 1886 that Frankel discovered the germ of this disease.

In diphtheria, or, as it was then known, malignant sore throat, no special treatment was used. Dr. Jarrett recalls distinctly the first case he attended. The oldest and most successful physician in Harford county had attended the family and lost three members of it in one week from diphtheria. Dr. Jarrett was sent for to attend the fourth patient who lived three weeks, dying of an exhausted heart. In 1883-4 the bacillus diphtheria was discovered by Klebs and Loeffler and it was not until 1892 that Behring gave the world his discovery, the antitoxin serum for diphtheria.

Dr. Jarrett has been contemporary with and profited by the discoveries of Pasteur, Koch, Behring, Lister, Flexner, Ross, Sternburg, Roentgen, Kleb, O'Dwyer and Ehrlich.

At the beginning of this sketch I quoted from the "Great Epochs in American History" showing the wonderful advancement in the political and economical conditions of the United States about the time of Dr. Jarrett's birth. We must not forget that there were here and there centers of physicians—good, strong, big-brained men, faithful to the responsibilities and trusts of the times in these early days, working that they might merit success and attain it; that it was as noble a profession then as it is today. That 60 years from hence we may be criticised for our crudeness and for being behind the times. All the developments and advancements made in the epochs I speak of were made by men who fulfilled the requirements of medical colleges of attending, in almost every instance, a two years' course.

In Dr. Jarrett's time (1851) he has seen the first attempt at the registration of births and deaths in New York city, the first law of its kind enacted in the United States, and yet, in 1912, we are compelled to speak of "the registration area" of the United States, as all the States do not require registration.

In 1857 was commenced in Scotland the more merciful, less restrained and scientific treatment of the insane and the criminal, and now an investigation is being made in our own State as to the charged inhuman treatment, "cuffing up" of the State's prisoners. These prisoners are classed by one of the State health officers as mostly degenerates.

A son, Dr. Harry S. Jarrett, is associated with the man we would honor in the practice of medicine. Dr. Martin L. Jarrett, of Jarrettsville, and Mr. William B. Jarrett of the Internal Revenue Service are brothers. He also has two daughters, Mrs. William A. Lee and Miss Julia Jarrett.

Dr. Jarrett has been a general physician attending to all of the practice that came to him as a country doctor. He has seen a number of epidemics. Being a busy man and medical societies far from him, he did not early acquire the habit that is now almost universal with the younger generation of physicians of

recording and reporting his cases. He is a member of the Medical and Chirurgical Faculty of Maryland and also a member and ex-president of the Baltimore County Medical Association, and is eligible to membership in the Sons of the American Revolution. Although advanced in years, he is still in active practice, attending to his patients each and every day, and takes an active interest in all the events of this bustling and hustling age.

It is our hope and prayer that we may be favored with Dr. Jarrett's presence, counsels and example for many years yet to come.

At the regular monthly meeting of the Baltimore City Medical Society, held October 18, 1912, Dr. Hugh H. Young, president of the Medical and Chirurgical Faculty of Maryland, presided. Dr. Todd read the above sketch of Dr. Jarrett's life, and on behalf of the Baltimore County Medical Association presented the portrait of Dr. Jarrett to the faculty, saying in part:

"The Baltimore County Medical Association presents to the Medical and Chirurgical Faculty of Maryland a portrait of Dr. James Henry Jarrett, one of the oldest physicians in Baltimore county, who has been in active practice since 1852, the year of his graduation at the University of Maryland. The association, in securing this portrait and presenting it to the faculty, requests that it may hang on the walls of its building as a memorial for all time to a member of the medical profession we consider it a delight and a privilege to honor. We also wish to establish a precedent which we hope other county societies will follow, thereby honoring their old members while they are still among them."

Dr. Young accepted the portrait on behalf of the faculty, eulogizing Dr. Jarrett and praising the work of the artist, Miss Marie Deford Kellar. Drs. Tanneyhill and Neff, contemporaries with Dr. Jarrett, spoke with much feeling as to their friendship and high esteem in which they held Dr. Jarrett. The criticisms of the members present were very favorable of the portrait of Dr. Jarrett.

WHAT TO DO IN CASES OF POISONING. By William Murrell, M.D., F.R.C.P.; Senior Physician to the Westminster Hospital; Lecturer on Clinical Medicine and Joint Lecturer on the Principles and Practice of Medicine; Late Examiner in the University of Edinburgh, Glasgow and Aberdeen, and to the Royal College of Physicians of London. Eleventh edition. New York: Paul B. Hoeber. 1912. Cloth; \$1 net.

This volume is indeed the acme of much in little. There is an old saying that valuable goods come in small packages, and this book is no exception to the rule. The only criticism that can be offered is the smallness of the type. To our way of thinking, the volume would be made more useful by enlarging the type. This, however, is a minor defect, especially when taking into consideration that the book takes up so many different varieties of poisoning and treats them in such an exceptionally admirable manner. The present edition has been thoroughly revised and brought up to the minute.

RURAL SANITATION; OR, PHYSICAL BETTERMENT IN COUNTRY LIFE.¹

By C. W. G. Rohrer, M.D.,
Maryland State Department of Health.

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I. INTRODUCTORY.

I AM very glad for the opportunity of addressing this audience upon so important a topic as "Rural Sanitation." As every intelligent person must know, this subject has been sadly neglected. Hitherto it has been customary to give precedence to all other matters of public interest, thus crowding out sanitary questions entirely. But there has been a public health awakening, and the people of this State are beginning to realize that good health is a most valuable asset, and that without it one can scarcely hope to succeed in any avocation in life.

Rural sanitation might be aptly compared to a gigantic oak tree with many branches, of which the most important are the following:

- (a) Personal hygiene.
- (b) Sanitation in the home.
- (c) Hygiene of infancy and childhood.
- (d) Food and drink.
- (e) Preventable diseases.
- (f) Sewage and drainage.²

II. PERSONAL HYGIENE.

Personal hygiene is the highway to health and the byway to longevity. Who is there among you who does not desire to live

¹Paper read before the Ladies' Club of Glyndon, Baltimore county, Maryland, on Thursday afternoon, June 27, 1912, at 4 o'clock; and also before the Men's Club of Reisterstown and Glyndon at 8.30 P. M. on the same date.

²I had originally intended to include a seventh subheading, namely, "Care of the Teeth," but was deterred from doing so upon reading what Dr. John Brown, in his little work entitled "Health: Five Lay Sermons to Working People," has to say about teeth on page 81.

"I had a word about *Teeth*. Don't get young children's teeth drawn. At least, let this be the rule. Bad teeth come of bad health and bad and hot food and much sugar. I can't say I am a great advocate for the common people going in for toothbrushes. No; they are not necessary in full health. The healthy man's teeth clean themselves, and so does his skin. A good dose of Gregory often puts away the toothache. It is a great thing, however, to get them early stuffed if they need it; that really keeps them and your temper whole."

long? Life is sweet—and beautiful if we make it so.³ To the lover of nature the seasons, each possessing a peculiar charm which is all its own, come and go with amazing rapidity. We cannot, like Joshua of old, command the sun to stand still; but, debarring accident and preventable disease, we may, by paying strict attention to personal hygiene, prolong life to the latest limit.

A short time ago I added to my library a very rare and interesting book published in London in 1799. It is entitled *Human Longevity*,⁴ and contains the names of 1712 persons who passed the age of 100 years. Naturally enough, I was deeply interested, and desired to know something of the habits and manner of living of at least a portion of this remarkable group of centenarians. Hurriedly turning the pages, I found the record of a man who died near London, England, at the advanced age of 110 years. He had never been ill, and had maintained through life a cheerful, happy temperament.⁵ The following is a summary of this

³As Henry Wadsworth Longfellow, the most popular American poet, born in Portland, Maine, February 27, 1807; died at Cambridge, Mass., March 24, 1882, wrote in his diary: "We have but one life here on earth; we must make that beautiful." His motto was: "Look not mournfully into the past—it comes not back again; wisely improve the present—it is thine; go forth to meet the shadowy future without fear and with a manly heart." Of him Edmund Clarence Stedman has said: "His song was a household service, the ritual of our feastings and mournings; and often it rehearsed for us the tales of many lands, or, best of all, the legends of our own. I see him, a silver-haired minstrel, touching melodious keys, playing and singing in the twilight, within sound of the roars of the sea. There he lingers late; the curfew bell has tolled and the darkness closes 'round, till at last that tender voice is silent, and he softly moves unto his rest."

⁴The following is a copy of the dedicatory page of Easton's book. Its full title is, "Human Longevity: recording the Name, Age, Place of Residence, and Year of the Decease of 1712 Persons, who Attained a Century & Upwards, from A. D. 66 to 1799, comprising a period of 1733 years. With anecdotes of the most remarkable." By James Easton.

TO THE OLDEST MAN ALIVE.

Whoe'er thou art, of whatsoever station,
Kindly accept this humble Dedication:
And may You long the envy'd boon enjoy,
Pure Nature's choicest gift, without alloy!—
But while to You I dedicate my Page,
O, might THEY listen—THEY of Younger Age!
Who careless now, beneath the morning beam,
Glide swiftly down Corruption's fatal stream,
May THEY peruse, with profitable care,
My Book—and learn, from each example there,
To follow Nature, in her frugal plan,
And thus to lengthen out their little span!
Not Galen's skill, or Aesculapian rules,
The pride of learning, or the boast of schools:
But Temperance, Exercise, and all the train
Of Sober virtues, chase disease and pain:—
So shall my humble labours merit praise,
And future PARRS be blest with honor'd days!

Salisbury, October 1, 1799.

Consult also, in this connection, pp. 116-131 of a quaint little volume by J. D. Koogle, entitled "The Farmer's Own Book," published in Baltimore in 1857. Among recent literature Dr. H. F. Harris' book, "Health on the Farm," and Ernest Ingersoll's "Animal Competitors," should be in the library of every dweller in suburban and rural districts.

⁵A bard of our own profession has beautifully sung:

"Whatever cheerful or serene
Supports the mind, supports the body too;
Hence, the most vital movement mortals feel
Is hope: the balm and life blood of the soul;
It pleases and it lasts."

man's treatment of himself, with a few additional notes on his personal history and hygiene:

He was unusually kind and obliging to everybody; he quarreled with no one; he ate and drank merely that he might not suffer from hunger and thirst, and never beyond what necessity required; from his earliest youth he never allowed himself to be unemployed. These were the only means he used.

Continuing my search, I next read the account of a woman who died near Stockholm, Sweden, at 115 years of age. It is stated that she never was ill, and was always of a contented disposition. Her methods of personal hygiene can be summed up as follows:

She always had a great love of cleanliness, and was in the daily habit of washing her face, hands and feet in cold water, and, as often as opportunity offered, she bathed in the same. She never ate or drank any delicacies or sweetmeats, seldom coffee, seldom tea, and never wine.

I have noted a third instance, which brings out several additional features in personal hygiene. It is that of a man who died near St. Petersburg, Russia, having enjoyed good health until he was 120 years old. The following is a synopsis of his daily habits:

He was an early riser, and never slept beyond seven hours at a time; he never was idle; he employed himself chiefly in the open air, and particularly in his garden; whether he walked or sat in his chair, he never permitted himself to sit awry or in a bent posture, but was always perfectly straight. The luxurious and effeminate habits of citizens he held in contempt.

These three examples suffice to show that simple habits of life are conducive to health and longevity. Before dismissing from our minds the book on *Human Longevity*, it might be interesting to mention that two of the 1712 persons described therein were Marylanders, as follows:

(1) Francis Ange, aged 134 years. Of Maryland. He was born at Stratford-upon-Avon, Warwickshire. He remembered the death of King Charles I. and left England soon after; his wife at 80 had a son, who was 31 years of age at his father's decease, to which time his faculties were perfect and memory strong. Died in the year 1767.

(2) William Hunt, aged 113 years. Of Maryland; the oldest inhabitant there. Died in the year 1772.

From another source I have obtained the record of a third Marylander who lived considerably beyond the century mark. It is as follows:

William Prigden. Of Maryland. Died October, 1845, aged 123 years.

I am sure that enough has been said to convince the most skeptical that personal habits and personal hygiene have much to do with the welfare of an individual. These pertain especially, as illustrated above, to personal cleanliness, habits of industry, hours

of sleep and articles of food and drink. That "cleanliness is next to godliness" has been amply demonstrated." A warm bath, for example, is needed—

(1) For purposes of cleanliness.

(2) To remove infectious materials from the surface of the body.

(3) To keep the skin healthy and active, thus warding off coughs, colds, and even pneumonia.

Many persons living in rural districts are not provided with ample facilities for bathing. For this reason they suffer much inconvenience. But I believe the day is not far distant when every country home will have its bathroom, its electric lights and its gas range. Our country homes are the bulwark of the nation, and we should do all in our power to make them more attractive and convenient. Such a step would undoubtedly prevent many boys and girls from becoming dissatisfied and drifting from the country to the city, oftentimes to their own detriment and to the detriment of the homes which they leave desolate.

While I fully believe that "industry is itself a treasure," I know only too well that many persons living in rural districts work too hard. This is partly due to the fact that suitable help is so difficult to obtain. Above all others, it is usually the housewife and mother who is overworked. Sometimes it is the growing boy or the growing girl.

When a mother nursing her child is overworked, injury is done both the mother herself and to her offspring. The former, for humanity's sake, and the latter, for its own sake, should receive more considerate treatment. In regard to the boys and girls, they are many times physically taxed beyond their years, stunting their growth and making them prematurely aged. The Child Labor law is doing much good in the prevention of such occurrences.

I still believe in the old adage, "Early to bed and early to rise." Everyone needs a goodly amount of "tired Nature's sweet restorer—balmy sleep."⁷ But the number of hours needed varies in different individuals. For example, Napoleon Bonaparte and Sir Walter Scott only slept 4 hours out of the 24, and Ralph Waldo Emerson only allowed himself 2 hours sleep. Most adults, however, require six or seven hours, and children proportionately longer, because every hour that a child sleeps means so much energy stored up for future use.

⁶Dr. John Brown, the genial author of "Rab and His Friends," in his booklet previously mentioned, metes out the following advice on page 58:

"Now, first, for the skin. You should take great care of it, for on its health a great deal depends: keep it clean, keep it warm, keep it dry, give it air; have a regular scrubbing of all your body every Saturday night, and if you can manage it, you should every morning wash not only your face, but your throat and breast with cold water, and rub yourself quite dry with a hard towel till you glow all over. You should keep your hair short if you are men; it saves you a great deal of trouble and dirt.

⁷From Edward Young's *Night Thoughts*. The full stanza is:

"Tired Nature's sweet restorer, balmy sleep!

He, like the world, his ready visit pays

Where fortune smiles: the wretched he forsakes."

The question of food and drink will be discussed under another heading.

III. SANITATION IN THE HOME.

A high and dry location is best for the home, be it urban, suburban or rural.⁸ As the female portion of the population spend a large part of their time in the house, the site cannot be too carefully selected. In this latitude, whenever practicable, a house should face the east or the south, thus ensuring the maximum amount of sunshine during the winter months. A few trees planted on the north or northwest side will act as a protection from wind and storm, but the shade should not be too dense, else the house will be damp and unhealthy, making those who dwell therein subject to rheumatic and pulmonary complaints.⁹

As a rule, the location of most of our country homes is ideal. But many times the house is either too large or too small. If too large, it is insufficiently heated; if too small, the air space per individual is inadequate.¹⁰ Many country homes do not have enough window space, and it is exceedingly uncommon to find one that is

⁸Florence Nightingale, in her admirable "Notes on Nursing," has the following to say, on page 24, concerning the health of houses:

"There are five essential points in securing the health of houses—

- "1. Pure air.
- "2. Pure water.
- "3. Efficient drainage.
- "4. Cleanliness.
- "5. Light.

"Without these no house can be healthy. And it will be unhealthy just in proportion as they are deficient."

⁹Dr. Henry Ingersoll Bowditch of Boston, in his able address before the Massachusetts Medical Society, called attention to the frequent connection between cases of pulmonary consumption and dampness of the soil upon which the patients lived. After a very extended and laborious investigation, Dr. Bowditch formulated these two propositions:

"*First*—A residence in or near a damp soil, whether that dampness be inherent in the soil itself or caused by percolation from adjacent ponds, rivers, meadows or springy soils, is one of the principal causes of consumption in Massachusetts, probably in New England, and possibly other portions of the globe.

"*Second*—Consumption can be checked in its career, and possibly—nay, probably—prevented in some instances by attention to this law." (*Viâe* Dr. Bowditch's memoir, "Consumption in New England and Elsewhere," second edition, p. 877. Boston, 1866.)

¹⁰In Besant's excellent little brochure, "The Law of Population: Its Consequences and Its Bearing Upon Human Conduct and Morals," there occurs the following paragraph on page 19:

"Overcrowding in country districts is, naturally, not so injurious to health as it is in the towns; the daily work in the open air, the fresh breeze blowing round the cottage, and cleansing, to some extent, the atmosphere within; the fields and lanes where the children can play—all these things may do much to neutralize the harm to health wrought by overcrowding at night. The injury to health, caused by large families among the agricultural poor, arises more from other causes than from overcrowding; the low wage cannot afford a house sufficiently good, and the cheap, ill-built cottage, damp, draughty, badly-drained, brings to those who live in it the fever, and the ague, and the rheumatism so sadly common among these laboring classes. But the moral effect of overcrowding is, so the present Bishop of Manchester said—when serving, as the Rev. J. Fraser, in the Royal Commission on the employment of children, young persons, and women in agriculture—"fearful to contemplate." 'Modesty,' he goes on, 'must be an unknown virtue, decency an unimaginable thing, where, in one small chamber, with the beds lying as thickly as they can be packed, father, mother, young men, lads, grown and growing up girls—two and sometimes three generations—are herded promiscuously; where every operation of the toilette and of nature—dressings, undressings, births, deaths—is performed by each within the sight or hearing of all; where children of both sexes, to as high an age as twelve or fourteen, or even more, occupy the same bed; where the whole atmosphere is sensual, and human nature is degraded into something below the level of the swine.'"

properly ventilated.¹¹ There are two principal reasons for this state of affairs, both of which can be easily overcome:

(1) Our rural population has not been properly educated in the art of ventilation.

(2) In a country home it is rare to find windows which can be lowered from the top, and in order to ventilate a room properly this must be done.

In many country homes sunlight and fresh air are rarely permitted to enter the living-rooms, to say nothing of the spare-rooms. In order for the occupants to retain their good health, it is necessary that ventilation should be properly done, both summer and winter. This applies with even greater force to sleeping-rooms, where each adult should have at least 1000 cubic feet of air space, or the equivalent of a room which is at least 10x12x9 feet. The rural part of our population is especially derelict in regard to the ventilation of living-rooms and bed chambers. Season should be no barrier, a fall in the outdoor temperature being met by heavier bed covers or an additional blanket.¹²

Other essentials are a wholesome and abundant drinking-water

¹¹Walter Noel Hartley, F.C.S., in his work entitled "Air and Its Relations to Life," it being the substance of a course of lectures delivered in the summer of 1874 at the Royal Institution of Great Britain, discourses as follows concerning the air of close places on pp. 73 and 74:

"It has been experimentally proved that *when the heat is not excessive the organic matter charging the air of crowded places rises in amount as the carbonic acid increases*, so that in the estimation of carbonic acid we have a measure of foulness of the air, or, as it may be termed, want of ventilation. Coming from the outside into a room in the condition we call 'close' or 'stuffy,' we enter an atmosphere which does not contain less than six volumes of carbonic acid in 10,000 of air. But the 'closeness' is detected generally by the nose, and is the effect of organic exhalations rather than of carbonic acid; nevertheless, the two are hand-in-glove, so the carbonic acid, which can be measured with greater certainty and ease than the other pollution, tells the story for both."

¹²Dr. Dio Lewis, on pp. 64 and 65 of his excellent little volume entitled "Weak Lungs, and How to Make Them Strong," writes as follows in regard to night air:

"Many persons indulge in a very silly dread of a draught. It is only by motion in the atmosphere that our lungs obtain the purest air. If at night the air moves briskly directly over your bed, your lungs will receive precious supplies. If you cannot endure this direct draught, you must deny yourself a great luxury. I once thought that a draught at night directly over my head was a thing to be avoided. Now I seek it as one of the real blessings of life. My wife, who inherited a consumptive taint, was ever guarding against night air. Now she sleeps with two open windows at one end of the bed and an open door at the other. Neither of us have had a cold for several years. Everyone must exercise his own judgment and prudence. I should be sorry were my words to lead anyone into an injurious exposure. But among the many hundreds—I might say thousands—whom I have advised to sleep with open windows, I have never known a single person to be seriously injured, even temporarily; and I may add that, almost without exception, so far as I have known, they would not return to their former habit of sleeping in unventilated rooms. At first you may contract a cold, but if you bathe freely in cold water and employ vigorous friction upon the parts exposed while in bed, even this may be avoided. But after a few weeks' experience it will be quite unnecessary for the physiologist to lecture you on the subject. You will yourself take to exhorting your friends upon the importance of well-ventilated bedrooms. One of the compensations of our great war will be found in the conviction among a million returned soldiers that night air is not a poison, and that draughts are less dangerous than Minie balls."

supply,¹³ good drainage and screening of the houses to protect from flies and mosquitoes. The barn and other buildings should not be erected in too close proximity to the house, and close association with dogs, cats and other domestic animals should be forbidden as dangerous. Heating a house is also a great problem. Most living-rooms are really overheated, 40 per cent. of the diseases of winter resulting therefrom.

IV. HYGIENE OF INFANCY AND CHILDHOOD.

" 'Tis education forms the common mind,
Just as the twig is bent the tree's inclined."

Much has been written concerning the hygiene of infancy and childhood.¹⁴ In the language of that inimitable humorist, the late Mark Twain:

"When the toast works down to the babies, we stand on common ground, for we've all been babies."

Yet the odds are frequently against this helpless bit of humanity. Very often he is not given proper food at proper intervals. He is permitted to sit on the cold, damp floor, perchance laden with dust and disease germs. Every "granny" in the neighborhood is permitted to kiss him, to say nothing of countless relatives and casual acquaintances.

With the exception of a baby's feet, he is nearly always too warmly clad. Summer and winter he is rolled about in his little carriage, with the full glare of the noonday sun shining directly into his eyes. Is it any wonder that eye diseases are becoming so prevalent in children?

In midwinter he is suddenly taken from an overheated house to the zero weather outside. Ofttimes his slumber is disturbed by flies in summer and unnecessary noise in winter.

¹³Dr. Edward Smith, in his excellent book on "Foods," p. 269, writes as follows concerning water:

"It is needless to insist that water is a most important food, for it is found in all foods, whether solid, liquid or gaseous, and is taken into the body to the amount of several pints daily. It, moreover, constitutes about 87 per cent. of the whole bulk of the body, and as it wastes at every moment, it must be restored by a new supply.

"It is required for many purposes: First, to soften or dissolve solid foods, so as to facilitate their mastication and digestion; second, to maintain a due bulk of blood and the structures of the body; third, to keep substances in solution or suspension whilst moving in the body; fourth, to supply elements in the chemical changes of the body; fifth, to enable the waste material to be carried away from the body; sixth, to discharge superfluous heat by transpiration through the skin and by omission through other outlets, and seventh, to supply in a convenient form heat to, or to abstract heat from, the body. Some of these functions are performed by water in its liquid state, and others in a state of vapour."

¹⁴Dr. Elizabeth Blackwell (1821-1910), the first woman to receive a medical degree, in a series of lectures delivered in the spring of 1852 entitled "The Laws of Life, with Special Reference to the Physical Education of Girls," spoke as follows:

"What, then, must be done in order to save the rising generation from the physical weakness and disease, with their attendant evils, which prevail so widely in the present race, and which are rapidly increasing in extent?

"I answer, first: The domestic habits of our households must be changed for children; their food, dress, sleeping apartments, and hours for rising and retiring must be regulated with scrupulous regard for their physical welfare and according to the principles so often laid down in the course of our remarks.

"Second: The system of school discipline must be essentially modified. The period of life from seven to sixteen being regarded as the special season of physical growth, the bodily development must be considered as the basis of all true education; we must cease to force the learning of a later period upon the youthful mind at that age."

A century ago William Wordsworth wrote the well-known sentence: "The child is father of the man." It is a figure of speech especially applicable to the hygiene of childhood. In order to rear a healthy child, there is no better place than a well-kept country home.¹⁵ In addition, there are three valuable adjuncts, namely:

(1) Nutritious food given in proper amounts and at regular intervals.

(2) Plenty of fresh air, sunshine and outdoor exercise.¹⁶

(3) An abundance of sleep.

Only wholesome and nutritious food should be given to a child.¹⁷ It should be rather "quality, not quantity." This is the only way to lay a sure foundation of health and endurance, both of which traits are necessary to enable one to take his or her place among the world's workers.

V. FOOD AND DRINK.

Good food and a wholesome environment are paramount in a child's life. Children who are poorly fed do not become towers of physical strength nor giants in intellect. There is much in the old proverb, "Give me the first seven years of a child's life, and you may have the rest," because in these early years the foundations of a strong manhood or sturdy womanhood are laid. For purposes of comparison, take a breast-fed baby and one brought up on an indifferent grade of cow's milk. As a rule, the former

¹⁵Dr. John Stockton-Hough, in a paper entitled "On the Relative Influence of City and Country Life, on Morality, Health, Fecundity, Longevity and Mortality," read before the Social Science Association of Philadelphia in the year 1874, concludes with the following paragraphs:

"Large towns have been emphatically called the *graves of humanity*, and certainly they are not favorable to health and longevity. Indeed, they might be very properly compared to the fiery furnace into which the condemned children were cast.

"Those who would live to a good old age and hand their names down through a numerous posterity in children endowed with rich mental gifts should avoid the dangers of the great city and choose the country life.

"It cannot be denied that cities are absolutely necessary for the fostering of the arts, the sciences, the elegancies of life, yet when they are so dearly bought, one cannot help the reflection, as he looks with wonder and admiration at these productions, of how many precious human lives they cost—of how many premature deaths—of how many souls are sacrificed on the altar of the arts.

"The tender mother who has reared the helpless babe in the pure and quiet rural home, and watched it learn to walk and tell its name—studied the growth of character and development of feature—until budding into healthy, innocent manhood or womanhood—if she allow her offspring to choose the city as the field of their fortunes and fancies, with its sins and its syrens, its vices and its vanities, its ills and its iniquities, its pitiless poverty, though mingled with elegance and luxury, with indolence and ease, its follies and frivolities, so attractive to us all—I say if she loose him to all these without her guiding care, and have but little left, as is too often the case, but a misspent life—a wretched wreck, or an untimely death—well may she exclaim with the Roman poet—*Pericula mille sacrae urbis*."

¹⁶William Cowper (1731-1800), in his poem *The Task*, expresses this sentiment most beautifully. He wrote:

"God made the country, and man made the town.
What wonder then that health and virtue, gifts
That can alone make sweet the bitter draught
That life holds out to all, should most abound,
And least be threatened in the fields and groves."

¹⁷The quantity of food for a child from five to fifteen should be from one-quarter to one-half as much as a workingman eats. The common notion that when a child is growing he needs unlimited quantities of food is an error.

will far surpass the latter in both brain and brawn, as well as in energy and powers of endurance.¹⁸

Residents in country districts are especially blessed so far as good, wholesome food products are concerned. Everything is first class and first hand. Cold-storage chicken and cold-storage eggs are unknown. Concerning raw foods, however, I wish to sound a note of warning. It applies to cabbage, lettuce, spinach and other garden vegetables which are eaten raw. In certain sections of Baltimore county these were formerly fertilized with "night soil," a pernicious and dangerous practice. In this manner many infectious diseases, notably typhoid fever, dysentery, tape worms, etc., are communicated.

In regard to the quantity of food consumed, I might formulate the axiom: *All of us eat too much; none of us eats too little.* So many of us, as it were, dig our graves with our teeth. Eccentric John Abernethy, an eminent English surgeon, used to say that "one-fourth of what we eat keeps us; the other three-fourths we keep at the risk of our lives."¹⁹ If we were more careful not to eat too much, many attacks of biliousness, sick headache, gout, rheumatism and uric acid diathesis could be avoided.

The nature of the food which we eat should be regulated according to the season of the year. During the winter season much fatty food is desirable and necessary; in the spring of the year.

"When the green gets back in the trees
And the bees get to buzzin' again,"

the heavy, greasy articles of diet, so beneficial during the winter months, should be changed to one more cooling and refreshing. We should eat more lettuce, spinach, spring onions, tomatoes, strawberries, etc., and drink less sassafras tea to "thin the blood."

Many country folks make a big mistake by going out into the hot sun immediately after eating a hearty meal. Sunstroke, apoplexy, acute indigestion and heart failure occasionally result.

¹⁸Dr. M. L. Holbrook, in his little book entitled "Eating for Strength," makes the following statement on p. 32 in reference to the daily wants of the human body:

"The requirements of the body vary with age, sex, occupation, health, work done, climate and race. Therefore, any attempt to decide just how much any person should eat would be fruitless. Still, some facts may be useful and instructive. In the first place, it may be stated that as a general rule a healthy man requires from 700 to 800 pounds of perfectly dry food in a year. This amounts to about two pounds of solid matter daily. In addition to this are required from five to six pounds of fluid. So, again, a man cannot live well on the meager diet of a pound of bread daily, with water, but will become thin and weak. It is said that the poor needle-women of London almost starve on a daily allowance of a pound and a half of bread and an ounce and a half of butter daily."

¹⁹I like the anecdote told of Mr. Abernethy (1764-1831), one of the ablest English surgeons of the past and a pupil of the celebrated John Hunter (1728-1793):

A distinguished duke waited upon that blunt, but excellent, surgeon with reference to a disease of his eyelids. He said: "Doctor, I am afraid there is serious mischief here," touching his eyes. The doctor, who had a great horror of talking patients, said: "My Lord, if you will keep silent and let me do the talking, I will tell you what your trouble is. Your disease is not where you think it is. The real malady is here," touching his Lordship's immense stomach. "Your kitchen is foul, and, of course, the poisonous effluvia will ascend to the garret. In your case, it shows itself in the eyes. Now, if you will clear the kitchen, the garret will require no special purification. You must do, my Lord, as the great Duke of Wellington has done in several of his famous sieges—cut off the supplies, and the enemy will leave the citadel."

especially in persons beyond middle life.²⁰ A respite of 15 or 20 minutes after a full meal may be the means of averting such an attack. While dwellers in rural districts are not much given to after-dinner speaking, I might mention that it is not unattended with danger. To cite two examples, reference needs only be made to the late Dr. I. N. Love of New York, and the late Hon. William Windom, Secretary of State, both of whom dropped dead while making an after-dinner speech.

In regard to drink, there is nothing like good, pure, cool spring water or cool well water—so cool that the addition of ice is unnecessary.²¹ I am opposed to the use of very much ice, and it has even been asserted that drinking ice-water is a cause of appendicitis. There is unquestionably some truth in this statement, because the imbibition of large quantities of ice-water causes a catarrhal condition of the intestines, which may extend to the appendix.

Milk is a good, nutritious article of drink for young persons, but I question its use in persons beyond middle life. It should be drunk very slowly, sipped, in fact, instead of gulped down, as is usually the case.

²⁰Dr. H. C. Wood, Jr., on pp. 9 and 10 of his essay on "Thermic Fever, or Sun-stroke," published in 1872, makes the following statement concerning the causation of the malady:

"In the first place, in regard to the etiology of the disease, my own experience is that the only absolutely necessary and the everpresent, immediate cause is heat, solar or artificial. It was formerly believed that exposure of the head to the direct rays of the sun was requisite, but this is now well known not to be true. One of my own cases originated in a sugar refinery."

²¹W. P. Mason, in his notes entitled "Examination of Potable Water," says, on p. 5:

"It has been held as a golden maxim by one of our authorities on water analysis never to pass judgment upon a water the history of which is not thoroughly known."

(Continued next month.)

Book Reviews.

AUTOINTOXICATION AND DISINTOXICATION. An Account of a New Fasting Treatment in Diabetes and Other Chronic Diseases. By Dr. G. Guelpa (Paris). Translated by F. S. Arnold, B.A., M.B., B.Ch. (Oxon). With an Introduction by the Translator and a Chapter on the Use of the Method in the Treatment of Morphine Addiction by Oscar Jennings, M.D. (Paris). New York: Rebman Company. 1912. Cloth, \$1.25.

In a paper on "Starvation and Purgation in the Relief of Diseases," read before the annual meeting of the British Medical Society, Dr. Guelpa of Paris advanced an outline of a new treatment combining periods of abstinence with purgation, which had proven very beneficial in diabetes and other chronic diseases, and cited two cases, one of diabetes with commencing gangrene, and the other of severe and old-standing gouty arthritis, in which the "disintoxication" treatment gave remarkable results. The paper

excited but little attention amongst the English-speaking peoples, despite the reception it had evoked in Paris. As the French have been so impressed with its value, the translator opined there was something in the method, and has therefore translated the article so as to bring it more prominently before English readers. The conclusions of Dr. Guelpa are consequently available to English physicians, and as the treatment in the author's hands has been followed by such brilliant results, it certainly bears investigation with an unbiased mind. Candidly, we cannot agree with the conclusions of Dr. Guelpa, but never having investigated the method, are not in a position to pass upon its worth. The treatment in brief consists of abstinence of both liquid and solid food for four days, at the same time instituting a rigorous course of saline purgation. At the end of this period the Doctor claims the sugar will in most instances have disappeared from the urine. He admits that it will reappear upon the placing of the patient upon food, but not in so large an amount, and that it will finally entirely disappear if the treatment is reinstituted every four days for four-day periods. During the treatment water is allowed *ad libitum*. Though the method seems rather harsh and severe and unscientific, the proof of the pie is in the eating. At any rate, the volume affords interesting reading, and the time spent in it will be well worth while.

PHARMACOLOGY AND THERAPEUTICS. For Students and Practitioners of Medicine. By Horatio C. Wood, Jr., M.D., Professor of Pharmacology and Therapeutics in the Medico-Chirurgical College; Physician to the Medico-Chirurgical Hospital; Second Vice-Chairman of the Committee of Revision of the United States Pharmacopoeia. Philadelphia and London: J. B. Lippincott Company. Cloth, \$4 net. 1912.

With the host of good pharmacologies and therapeutics on the market, at first glance there would seem no need for the present addition. Such is not the case, however. As in all other lines of endeavor in medicine, so in the particular field of which this book treats, important changes are constantly being effected. This alone, if for no other reason, would justify the presenting of the present volume to those engaged in medicine. It should especially appeal to medical students from the simplicity of its arrangement. Chapter one is devoted to definitions, weights and measures, prescription writing, incompatibles, mode and action of drugs, theory of ionic action, circumstances modifying the action of drugs and mode of administration; chapter two, to drugs used to affect secretions (diuretics, diaphoretics, expectorants, drugs which diminish secretions); chapter three, to drugs used to affect nervous system (somnifacients, anesthetics, analgesics, spinal depressants, motor nerve paralyzants, sensory nerve paralyzants); chapter four, to drugs used to affect circulation (cardiac stimulants, vasomotor stimulants, drugs which reduce

drug pressure, treatment of chronic heart disease); chapter five, to drugs used to affect the alimentary tract (stomachics, emetics, cathartics); chapter six, to drugs used to affect metabolic processes; chapter seven, drugs acting on causes of disease (anthelmintics, antimalarials, disinfectants); chapter eight, extraneous remedies (digestants, alkalies, demulcents, emollients, counter-irritants, escharotics); chapter nine, drugs of minor importance. Dr. Wood, from a long experience as teacher, is well qualified to know the requirements of a medical student, and the balance he has struck in this production stamps him as a pastmaster in putting this knowledge on paper. Certainly the arrangement could not be more simple or comprehensive. The book should, on account of these features, appeal to medical students. The value of the book would have been enhanced if some space were devoted to antitoxins, vaccines, etc. We presume that the author considered serum therapy as a special field of therapeutics, the same as Röntgen therapy, and as such should be treated independently. Treatment by various serums by the general practitioner is becoming so prevalent that it is our opinion the student should be fully impressed with its usefulness at the earliest possible opportunity, which is during his course in materia medica. One realizes that a writer has to be guided by the character of his readers and the purpose of the book as regards what should be included and space allotted. As emphasized above, Dr. Wood has used excellent discrimination in the drugs selected for description and the amount of weight placed upon each. Its up-to-dateness, simplicity of diction and arrangement should secure for it the recognition and approval of teachers of therapeutics. General practitioners looking for a reliable reference book in therapeutics will be more than pleased with the information it contains.

SURGERY OF THE BRAIN AND SPINAL CORD. Based on Personal Experiences. By Prof. Fedor Krause, M.D., Geh. Medizinalrat Dirigierender Arzt am Augusta Hospital zu Berlin. English Adaptation by Dr. Max Thorex (Rush M. C., Univ. of Chicago), Surgeon-in-Chief American Hospital, Chicago, Ill.; Consultant Cook County Hospital, Chicago, Ill.; ex-Professor of Surgery, Bennet Medical College (President Loyola University), Chicago, etc. Volume II. With 94 figures in the text, 14 of which are colored, 27 colored figures and 4 halftone figures, on 15 plates. New York: Rebman & Co. 1912. Cloth, \$7 net.

Though surgery of the brain is still more or less in its infancy, yet through the observations of a host of workers much has been accomplished along the lines of correcting certain lesions, and the future offers still greater promise. Among the workers who have brought us to the present state of knowledge none stands out more prominently than Prof. Fedor Krause of Berlin. This indefatigable surgeon some time since brought his investigations and con-

clusions in book form to the attention of his German confrères. As the attempt was received so well by the readers, and was found of such universal interest to surgeons on the Continent, Rehman concluded to have it translated into the English language by Dr. Thorek, so that it would become available to those unable to read German. As we have not seen the first volume, it is impossible for us to appraise its worth. If it measures up to the standard of the one before us, however, English physicians are indeed fortunate in possessing two such meritorious books. The second volume represents the product of an immense amount of careful, painstaking, laborious investigation. This volume deals especially with epilepsy and the surgery of the spinal cord, and records faithfully and convincingly the protocols of Dr. Krause as formulated from a large personal operative experience in the affections under discussion. Often we take up foreign works with a hostile feeling. Such was the case here, but on a more intimate acquaintance from an antagonistic state of mind, almost imperceptibly, a feeling of cordiality takes possession of the reader, as he realizes he is in communication with a master mind.

THE NEW POCKET MEDICAL FORMULARY. With an Appendix Containing Formulae and Doses for Hypodermic Medication; Pöological Table; Obstetrical Table; Table of the Apothecaries' and Metric System of Weights and Measures; Fractures, Dislocations and Sprains; Ligation of Arteries; Hemorrhages and Wounds; Treatment of Asphyxia and Apnea; Poisons and Antidotes; Incompatibilities and Baths; Tables and Differential Diagnoses, Eruptive Fevers, Diet Lists for Various Diseases; Materials and Drugs Used in Antiseptic Surgery; Formulae for Fluid Foods, etc. By William Edward Fitch, M.D., Editor of *Pediatrics*; Adjunct Attending Gynecologist, Philanthropian Hospital; Formerly Lecturer on Surgery, Fordham University School of Medicine; Assistant Attending Gynecologist, Presbyterian Hospital Dispensary; Attending Physician to the Vanderbilt Clinic, College of Physicians and Surgeons, New York city; Member of the American Editors' Association; Member of the Medical Association of the Greater City of New York, etc. Philadelphia: F. A. Davis Company. 1912. Leather, \$2 net.

The author has been very conservative in the formulae which he has selected for use in the disease under which they are listed. In most instances he has given them a trial, and is therefore in a position to recommend this or that prescription from actual experience and observation. Further attractiveness is given the book by the inclusion of a table of differential diagnoses of the commoner diseases, a physicians' dose table, diet lists for a number of conditions, etc. A special feature is the size and binding, which are of such a character as to enable the book to be carried in a coat pocket.

MARYLAND MEDICAL JOURNAL

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ALEXIUS MCGLANNAN, M.D.

A. SAMUELS, M.D.

BALTIMORE, NOVEMBER, 1912

DIET IN DIABETES.

NATURE through some inherent power readily takes care of excess food, thus rendering it unnecessary to regulate the diet of a healthy individual. If this were not the case, the digestive and eliminative organs would soon be overwhelmed and a disordered body would result. When the eliminative system is not performing perfectly, this is not the case, and the diet cannot be left to the caprice of the individual. Many observers have already testified to the retention of the several components of the foodstuffs when the organ by which they should be removed is diseased or upon secretion the constituent is unchanged, even after passing through the process of metabolism. Because in health the body can convert a surplus of food into innocuous substances, one must not be led to the belief that such is the case in disease. In days past, if sugar were detected in the urine, the patient was immediately forbidden the use of this article, with bad results, no doubt, many times. Dieticians now recognize the importance of first determining the sugar tolerance before ordering a diabetic to abstain from the use of carbohydrates. As a matter of fact, these patients, if suddenly deprived of sugar, occasionally develop an acidemia, which means death, unless sugar is quickly restored to the diet. A very sensible article on the above title by P. J. Cammidge of London, in the *British Medical Journal*, says that the diet of diabetics must not be left to the dictates of the appetite. He thoroughly realized the ineffectiveness of drawing up a carbohydrate free diet, with the substitution therefor of a fatty and protein, as this course might be followed by a severe upheaval. Another reason he adduces against the method is that on an ordinary mixed diet some 70 per cent. of the energy of the body is usually derived from the foods of a carbohydrate nature, so that when these are excluded an equivalent amount must be provided from other sources if nutrition is not to suffer. He states further a

patient on a carbohydrate free diet, being deprived of his customary guides as to the amount of food required, is very likely to take an insufficient quantity to meet his energy requirements, or to consume an excessive amount of protein, if fats are distasteful. Rightly he concludes, if carbohydrate metabolism were the only factors at fault, its treatment would be comparatively simple, but as the secondary disturbances of metabolism have also to be taken into account, viz., in persistent glycosuria part of the sugar excreted in the urine is derived from the proteins of the food or tissue, mere restriction of the starchy and sugar foods is not sufficient to control the glycosuria. As a matter of fact, the best results are obtained by cutting down the intake of meat and allowing a certain amount of carbohydrate. This conclusion is in accordance with the views of most, if not all, modern investigators. For these reasons, he states, it is clear that the successful dietetic treatment of diabetes is not so easy to carry out as at first sight it might seem, and that the method of merely excluding carbohydrates from the diet is, after all, a very superficial and unsatisfactory procedure. No one today has the temerity to contradict or oppose the foregoing assertion. His idea is that what is really wanted is an adjustment of the food to the capacity and needs of the organism, quantitatively as well as qualitatively, which can only be accomplished by a thorough investigation of the metabolism in each case, based upon a series of analyses of the urine and feces when the patient is taking a diet of known composition. Practically the above observations are put into service by first determining the carbohydrate tolerance of the case and the particular forms of carbohydrate that are best metabolized. This determined, the patient is allowed to take each day a sugar so long as it is within the limits of tolerance. By this means considerable elasticity is given to the diet, the craving for starchy food allayed and the co-operation of the patient gained. It is quite unnecessary, indeed often harmful, to keep a patient on a strict carbohydrate free diet for any length of time. Dr. Cammidge, as well as others, have seen so much unpleasantness arise from the last-mentioned practice that he strongly urges its strict avoidance. Diet is coming to play such an important part in the treatment of disease, and the more that is learned about what can be done by proper observance of diet in disorders, the more one realizes the necessity of physicians making themselves thoroughly conversant with scientific feeding.

Medical Items.

DR. WILLIAM I. BUPPERT of Harrisonville, Md., is a patient in the University Hospital, suffering with a sprained knee due to a fall.

DR. SCURRY L. TERRELL, who is one of the physicians in attendance upon ex-President Roosevelt, is a graduate of the College of Physicians and Surgeons, class of 1893.

DR. HENRY CHARLES OHLE of 1203 W. Lombard street was awarded \$7500 by the Supreme Court in a suit against the Maryland Casualty Co. on a policy of insurance for being so badly infected while operating that he became totally blind.

DR. S. DEMARCO is on a two weeks' hunting trip in the Maine woods.

JAMES BUCHANAN BRADY of New York has given \$200,000 to the Johns Hopkins Hospital for the establishment of the first urological institute in America. Mr. Brady will also contribute \$15,000 annually to its support and leave a substantial annuity provided for in his will. Work will be begun on the new building in April. It will be six stories high, with a public ward and a number of private wards, and will accommodate about 50 patients.

DR. ABRAHAM SAMUELS has returned after four months spent in Northern New York.

DR. J. U. KIMBLE of Newberg, W. Va., was a recent visitor to Baltimore.

DR. THOMAS S. CULLEN has been appointed president and Dr. W. L. Moss secretary of the Johns Hopkins Hospital Medical Society.

DR. CHARLES BAGLEY, JR., has gone to Boston as assistant to Dr. Harvey Cushing at Brigham Hospital.

DR. AXEL HOLST of Christiania, Norway, spent some time visiting in Baltimore in October, and made a visit to the University Hospital to inspect the beri-beri patients who were brought there from the bark Daylight of Bombay.

THE engagement is announced of Miss Alice Whelan, daughter of Mr. and Mrs. Thomas A. Whelan, to Dr. Joseph Albert Chatard, Johns

Hopkins Medical School, '03, of 1225 Maryland avenue.

DRS. JOHN STAIGE DAVIS, W. T. Watson and Henry Lee Smith were appointed a committee of the Baltimore City Medical Society to investigate the causes and means of relief from street noises.

DRS. ERNST TENGWELL, Fritz Bauer and E. S. S. Hollingren of Sweden and Drs. P. A. Fenger and L. Karnberg of Copenhagen were recent visitors to Johns Hopkins Hospital.

DR. ISAAC DICKSON, who has been very ill with peritonitis, has sufficiently recovered to resume his practice.

THE twenty-first convention of the Association of Military Surgeons of the United States was held in Baltimore October 1. They were welcomed by the Governor of Maryland, the Mayor of Baltimore and by Dr. Hugh Young, president of the Medical and Chirurgical Faculty of Maryland.

DR. LOUIS FRIEDMAN has succeeded Dr. Geo. Battle, resigned, as assistant physician of the Municipal Hospital for Tuberculosis of Baltimore. Dr. James Murray was appointed an assistant physician at the same time.

THE engagement is announced of Miss Louise Dilworth Randall, daughter of Mr. and Mrs. Samuel H. Randall, of Baltimore, to Dr. Robert Lee Keyser. The marriage will take place October 31, 1912.

DR. HOWARD STEELE HOLLOWAY, University of Maryland, '03, formerly of Perryman, Md., who has been bacteriologist to the State Board of Health of Florida, has accepted the position of pathologist at the Hospital for the Insane, Chattahoochee, Fla.

THE engagement is announced of Miss Marian Boise, daughter of Mr. and Mrs. Otis B. Boise, to Dr. George Canby Robinson, Johns Hopkins Medical School, '03, of Rockefeller Institute, New York. The marriage will take place early in December.

THE American Surgical Association has appointed a committee consisting of Drs. Wm. L. Estes, South Bethlehem, Pa.; Thomas W. Huntington, San Francisco, Cal.; John B.

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BALTIMORE, MD.

Walker, New York City; Edward Martin, Philadelphia, and John B. Roberts, chairman, 313 South 17th street, Philadelphia, to report on the operative and non-operative treatment of closed and open fractures of the long bones and the value of radiography in the study of these injuries. Surgeons who have published papers relating to this subject within the last ten years will confer a favor by sending two reprints to the chairman of the committee. If no reprints are available, the titles and places of their publication are desired. John B. Roberts, chairman, 313 South 17th street, Philadelphia.

DR. ERNEST B. GAITHER of The Latrobe, Baltimore, desires to announce that his practice is limited to gastro-intestinal diseases.

DR. TOM A. WILLIAMS has removed to 1703 N street northwest, Washington, D. C.

DR. JAMES B. PARRAMORE, 17 West Church street, Jacksonville, Fla., who is well known in Baltimore, announces that he will limit his practice to surgery and gynecology.

The board of managers of the Home for Widows and Orphans of Physicians, Inc., will hold a bazar at the Howard Street Armory (over Richmond Market), Baltimore, on November 21, 22, 23 and 24 from noon to 11 P. M. daily. Lunch will be served from 11 to 2 at 25 cents, supper from 6 to 11 at 50 cents. The home is dependent entirely upon the efforts of its managers, and it is therefore hoped that the medical profession will give this its heartiest support.

Miss JANE NASH, former superintendent of the Fordham Hospital of New York, has arrived in Baltimore and taken up her duties as superintendent of the Church Home and Infirmary. She is the first woman to hold such a position in this State.

MARRIAGES.

JEPSON EDAM HAIR, JR., University of Maryland, '12, to Miss Ivy J. Kinney, University Hospital Training School for Nurses, class of 1911, both of Baltimore, at Philadelphia, Pa., October 21, 1912.

LLOYD PARKER SHIFFEN, M.D., Johns Hopkins Medical School, of 209 W. Monument

street, Baltimore, to Miss Florence Brush of Towson, Md., at Baltimore, October 2, 1912.

ALFRED TAYLOR BRONAUGH, M.D., of Washington, D. C., to Miss M. Katharine Reeder of Newberg, Md., at Baltimore, October 14, 1912.

SAMUEL LOGAN OWENS, M.D., Georgetown University School of Medicine, '03, of Washington, to Miss Clara Mullikin Weems of Winchester, Va., at Winchester, October 23, 1912.

EDWARD C. BENNETT, M.D., of Fayetteville, W. Va., to Miss Carrie Emerson of Baltimore, at Baltimore, October 15, 1912.

OLIVER NEWALL DUVALL, M.D., Atlantic Medical College, '01, to Miss Margaret Miller, both of Baltimore, at Baltimore, October 24, 1912.

DEATHS.

JOHN S. GARMAN, M.D., College of Physicians and Surgeons, '78, at his home in Berlin, Pa., October 2, 1912.

WILLIAM A. GARMAN, M.D., University of Pennsylvania, '49, father of Dr. John S. Garman, died of senile debility at his home in Berlin, Md., October 6, 1912.

HENRY JOHNS RHETT, M.D., University of Pennsylvania, '90, of Washington, D. C., at the Newport Hospital, Newport, R. I., October 7, 1912, following an operation.

LEWIS R. PALMER, M.D., Hahnemann Medical College, '92, of Baltimore, at the Hahnemann Hospital, Rochester, N. Y., of stomach trouble, October 1, 1912, aged 44 years.

HAROLD TOWNSEND PRENTISS, M.D., Baltimore Medical College, '93, at his home in Holyoke, Mass., aged 43 years.

NED M. JETER, M.D., University of Maryland, '87, died at his home in Millington, Kent county, Md., October 22, 1912, of heart disease, aged 50 years.

JOHN W. HUGHES, M.D., College of Physicians and Surgeons, '11, of Pawtucket, R. I., died in Westerly, R. I., September 20, 1912, of nephritis, aged 20 years.

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EXPERIENCE WITH TONSILLECTOMY*

By F. Hazlehurst, Jr., M.D.

THIS report is based upon two hundred and eighty tonsillectomies performed in the last four years, eighty-eight under local anesthesia, and the balance, one hundred and ninety-two, under ether.

Of the local anesthesia cases all but four were adults. Of these four children, who ranged in age from ten to twelve years, three had a heart lesion, and it did not seem desirable to employ general anesthesia. The fourth child was very robust and seemed well adapted to local anesthesia. All the ether cases were children with one exception, a young man of eighteen years, who preferred general anesthesia. In addition, there were three cases performed in children without any anesthesia. These were among the very first cases and were sufficient to demonstrate that such procedure is equally trying to both the child and operator, and in the writer's opinion unjustifiable.

The operations were done in a variety of conditions, and were done only in the presence of symptoms, local or systemic, which could be attributed to diseased tonsils. Except in acute conditions, such as acute tonsillitis and peritonsillar abscess, I find it extremely difficult to make out whether a tonsil is diseased in the absence of symptoms. We constantly see on routine inspection of the throat, when the main affection is in some other focus, tonsils which are large, reddened, contain crypts, more or less filled with debris, and which give absolutely no symptoms, local or constitutional; on the other hand, associated with an infectious arthritis, there may be a tonsil which is very small, of indifferent color, with no especially large amount of cryptic deposit, and very little history pointing to involvement of the throat, the removal of which causes complete disappearance of the arthritis. Among conditions regarded as sufficient reason for operating may be mentioned frequent sore throat, not of extreme grade, but enough to give the patient a great deal of annoyance, chronic bronchitis as-

*Read at Semi-annual Meeting of the Medical and Chirurgical Faculty of Maryland, November, 1912.

sociated with tonsils giving a great deal of secretion, and with a history of severe sore throat previously, enlarged glands in the neck, repeated quinsies, simple hypertrophy causing obstruction to breathing or swallowing, acute follicular tonsillitis which frequently recurred or had in its train acute rheumatic fever, heart lesion, or chorea, chronic aural discharge, infectious arthritis.

In dispensary practice one sees over and over again the close association of acute tonsillitis, acute rheumatic fever, endocarditis and chorea. I regret not having more complete records of the infectious arthritis cases. Three cases of acute infectious arthritis and four of the more chronic type which I followed showed undoubted benefit from tonsillectomy. It is quite probable that the discharge in many cases of chronic otorrhea comes not from the middle ear cavity, but from the naso-pharynx, a perforation in the ear drum, allowing naso-pharyngeal secretion to be discharged via the Eustachian tube. These cases may be marvelously helped by a thorough removal of adenoids and tonsils, or a focus of nasal suppuration. I had one case, a chronic otorrhea of several years' standing, with distressing odor, which cleared up, as if by magic, on the removal of the tonsils alone. Practically every case in children of tonsillar infection or hypertrophy is associated with enlarged cervical glands, especially beneath the angles of the jaw. Whether removal of the adenoids and tonsils tends to cause the disappearance of the glands, or as some have maintained tends to cause a constant reinfection because the faucial tonsils, which constitute the outer defenses, are gone, and the cervical glands must catch and take care of infection entering by way of the mouth, is a matter for careful statistical study. That repeated peritonsillar abscess can only be definitely controlled by tonsillectomy is illustrated in a patient, male, aged forty-four, who had had quinsy forty-four times in twenty-nine years. There was in this case an abscess cavity about one cm. in diameter on the outer superior wall of the tonsil.

Technic. Before considering the method of operation a word as to the anesthetics used and as to the method of administration. In most of the local anesthesia cases I have used novocain (said to be one-eighth as toxic as cocaine) in $\frac{1}{2}\%$ solution and adrenalin 1-6000 solution. In only one case have I used cocaine ($\frac{1}{2}\%$), and that through the mistake of a nurse. About a drachm of this solution is injected into the tonsil, the injection being made above, below and in the middle. The needle is thrust into the tonsil until a feeling of resistance indicates capsule or the wall of the tonsillar fossa. The solution is injected into the tonsil itself rather than into the pillars of the tonsil, as is done by many, in order to avoid possible intoxication either from the novocain or the adrenalin, in view of the theoretical consideration that systemic absorption would be greater if the injection is made where the blood vessels are larger.

The novocain and adrenalin combination seems eminently satisfactory. I have never observed any effects on the patient which

could be unmistakably due to the drugs used. In a number of patients, especially in certain rather nervous women, there has been complaint of violent headache and a feeling of oppression in the cardiac region, usually accompanied by accelerated pulse and some grade of dyspnea. It has always been difficult to decide whether these phenomena were not evidence of shock induced by a rather natural fear and prolonged holding of the breath. The occasion when these symptoms were most prominent was immediately after the first injection before one would think there had been time for any systemic absorption. That headache rather frequently comes from reflex apnea induced by the presence of the tongue depressor or tonsil instruments in the mouth seems quite probable.

In an endeavor to eliminate even the doubtful toxic effect of the novocain, I have employed quinine hydrobromide (1%) and adrenalin 1-7000 in three cases, and antipyrin (2%) and adrenalin 1-7000 in four cases, with excellent anesthetic results. Bearing in mind that normal salt solution injected in large quantity, several drachms to each tonsil, gives excellent results as far as anesthesia is concerned, I have used in seven cases diluted adrenalin solution 1-12000 in similar quantity, with fair anesthetic and good hemastatic results. The hemastatic effect of 1-6000 or 1-7000 adrenalin solution is excellent, and I have seen no case where there was a post-operative bleeding which was masked at the time of operation by its use. It seems to me quite probable that such post-operative hemorrhage might occur were the solution injected into the muscles of the pillars and the superior constrictor muscle in which run blood vessels of larger caliber. A decided advantage of the use of adrenalin in local anesthesia is that with little bleeding the apprehension of the patient is reduced to a minimum, whereas profuse hemorrhage is apt to produce alarm. As a provision for the comfort of the patient a nice sharp needle for use in injection need not be dwelt upon.

General Anesthesia. This I avoid whenever possible. Most of the fatal cases occurring in the performance of tonsillectomy have been general anesthesia cases. The greater danger to life and the post-operative discomfort, together with the possible injurious systemic effects of the drug, make it seem wise to limit its use. There are cases, however, examples of which are the neurotic women of the type mentioned above, to whom the shock of operation under local anesthesia is perhaps worse than the effects of the narcotic drug. Here the operator must exercise his judgment as to the choice of anesthetic. Owing to the elimination of the personality of the patient, the operation under general anesthesia is certainly less trying to the operator. It has seemed to me that the operation is easier to perform with the patient in a sitting position. There seems very little danger of the aspiration of secretions or blood under general anesthesia since the pharyngeal reflexes remain perfect to an extremely deep stage of narcosis. For this reason I felt safe in trying the operation in a sitting position in a

number of cases. Among these there were two who showed evidence of collapse and gave us a healthy scare. As a rule, the children looked more exhausted, though the operation was more quickly performed. Accordingly, I have given up the upright position for general anesthesia and operate with the patient lying flat upon the table with the head tilted to the side.

The great bugaboo in the mind of the physician in removing tonsils has been fear of hemorrhage. The common causes of hemorrhage and those over which the operator has control are cutting muscle—that of the anterior or the posterior pillar of the fauces, the superior constrictor muscle or the base of the tongue—and leaving tags of tonsil tissue. These tags of tissue containing blood vessels, which cannot normally retract because their walls are held apart by the firm tissues through which they pass, are a fruitful source of bleeding. I think every one who removes tonsils has observed that with the tonsil partly removed bleeding may be rather brisk, but with completed enucleation is markedly checked. A safe method of operation should avoid injury to muscular structures, should sever in order to get as little bleeding as possible, only the finest possible branches of the blood vessels supplying the tonsil; that is, the lines of cleavage separating the tonsil from the walls of the tonsillar fossa should be as close to the outside of the capsule of the tonsil as possible, and should obviously be conducted under the direct guidance of the eye—the cutting edge of the instrument employed should always be within view.

A study of various operative methods described in the literature will show that most of these methods, be it with dull or sharp dissection, provide for a separation of the tonsil and pillars by insertion of the cutting edge between the pillars and the tonsil, and hence out of sight. The use of the snare to remove the tonsil after separation from the anterior and the posterior pillars is a somewhat blind procedure. A portion of the superior constrictor muscle may be readily included and nipped off, especially where the tonsil is pulled through the lumen of the snare by forceps.

It is difficult in the present day to present a tonsil operation which differs entirely in methods from numerous others which have been reported. The method employed in the cases which I have operated I regard as a modification of the Ballenger scalpel operation, and greatly increases the safety of the operation. It embodies the two principles of safe operation mentioned above—the cutting edge of a small scalpel, as sharp as possible, being always within sight and the cut being always against the tonsil. The operation may be divided into the following stages:

First: Grasp the tonsil at the exposed inner surface with the forceps, pulling it forward and inward, and thus exposing the attachment of the anterior pillar to the tonsil.

Second: Incise this mucous membrane attachment only to a depth equal to the thickness of the membrane, cutting against the tonsil. The incision begins below, because here the boundary of

the anterior pillar can always be made out where it joins the base of the tongue, and is carried upward parallel to the arch of the anterior pillar to and across the upper pole of the tonsil as far as the posterior pillar. In this incision consists mainly my modification of Ballenger's operation. Ballenger at this point says: "Introduce the blade of the scalpel about one-half inch between the anterior pillar and tonsil at the junction of the pillar and the tonsil;" "sweep the blade upward to the margo supra tonsillaris and thence over the margo supra tonsillaris to the posterior pillar. The knife should be very sharp for this purpose." Obviously the insertion of a sharp scalpel one-half inch out of sight plus a sweep, even in skilled hands, is not the most careful method that might be used.

Third: Change of the grasp of the forcep to the upper pole of the tonsil, which is rotated downward and forward, putting some of the fibrous connections between the tonsil and the walls of the tonsillar fossa on the stretch. These fibrous bands are severed by a cut against the tonsil.

Fourth: Continue the process of rotating the tonsil inward, downward and forward, and severs fibrous connections by always cutting against the tonsil. The tonsil is thus stripped from the anterior pillar, superior constrictor-muscle and posterior pillar, the attachment to the base of the tongue being the last released. Frequently a portion of the lingual tonsil will be stripped up by this method, the lingual tonsil apparently being just a more closely adherent continuation of the faucial tonsil.

This method is very simple. The vital points, first the method of making the initial incision; second, the constant manipulation of the tonsil by means of the grasping forcep so as to continually expose more and more of its attached surface, and third, the cutting always against the tonsil. Every step is exactly within sight, the scalpel at no time being thrust between the pillars and tonsil, where the sharp point and cutting edge might, unseen, nick muscular structures.

The almost uniform absence of post-operative bleeding in this operation, in two hundred and eighty cases, justifies description of the operation. In these cases there were only three that had any post-operative bleeding; two of these were in children, one in an adult. One was due to the presence of a tag left at operation and ceased immediately on removal of the tag. The others had stopped spontaneously, one four hours after operation, the other six hours. The reason for the bleeding in these two cases I did not ascertain.

At operation the amount of bleeding varies according to whether local anesthesia in which the hemastatic effect of the adrenalin is at its best, or general anesthesia is used, and also from patient to patient. It is true that at times literally not more than a few drops of blood are lost under local anesthesia. In other cases bleeding may be rather brisk. If the bleeding shows any tendency to continue either under local or general anesthesia, the Jackson

tonsil haemostat clamp is used and a tie applied if deemed necessary.

Four patients above forty, aged respectively forty-four, forty-five, fifty-one and fifty-seven, were operated on. In none of these was there any more bleeding than in the young adults.

While I do not claim that even the most conscientious and skillful execution of the above described method will do away entirely with hemorrhage, I do think that such a method reduces it to a minimum, and with the clamps to fall back upon when necessary makes tonsillectomy a safe surgical procedure.

230 West Lafayette avenue.

THE PATHOLOGY AND TREATMENT OF DISEASES OF WOMEN. Fourth edition. Rewritten by A. Martin, Professor and Director, Der Universitaets-Frauenklinik in Greifswald, and Ph. Jung, Professor and Oberarzt, Der Universitaets-Frauenklinik in Greifswald. Only authorized English translation, written and edited by Henry Schmitz, M.D., Professor of Gynecology, Chicago College of Medicine and Surgery; Medical Department, Valpariso University; Attending Surgeon, St. Mary of Nazareth Hospital; Attending Gynecologist, Frances E. Willard National Temperance Hospital, Chicago. With 187 illustrations, 25 of which are in colors. 1912. New York: Rebman Company. Cloth, \$5 net.

As the number of American physicians and students who read German is limited, it is impossible for this class to get at first hand the latest ideas and thought of our German *confrères* unless some competent translators put them into English. Americans are prone to the belief that only our nationality is concerned with surgical advancement. Such is not the case, however, as many advances originate with our foreign brothers. Therefore, it is meet that books which have been found beneficial in other lands should be translated so that the American profession may benefit thereby. Although there would seem to be at first glance an oversupply of good gynecologies on the market, yet we must realize that each and every one of these has its deficiencies and limitations, its friends and enemies. Though the volume before us is not large when it comes to the number of pages, what it lacks here it makes up for in substances and illustrations. One is particularly impressed with the simplicity and naturalness in the arrangement of the subject and with the elimination of a horde of befuddling theories which only confuse the student. Certainly a student or general practitioner should obtain a clear picture of the anatomy, symptomatology, pathology, operative and non-operative technique of the common women diseases, as each and every part of the female generative tract is sufficiently, fully and comprehensively treated. It presents the subject so graphically and logically that it gives us great pleasure to recommend it unqualifiedly to the medical profession.

RURAL SANITATION; OR, PHYSICAL BETTERMENT IN COUNTRY LIFE.

By C. W. G. Rohrer, M.D.,
Maryland State Department of Health.

(Continued from November issue.)

VI. PREVENTABLE DISEASES.

In the field of preventable diseases there is much to be done in the rural districts. The country is looked upon as the stronghold of typhoid fever, and if these scattered remarks tonight enable one person to ward off an attack of this dread disease, I shall feel amply repaid for my efforts.

The rural and suburban portions of our population—some 600,000 souls—possess but slight knowledge of preventable diseases. This is to be deplored, because many valuable and useful lives are prematurely ended through the intervention of infectious or preventable disease.²²

The most important infectious or preventable diseases are the following: Tuberculosis, typhoid fever, scarlet fever, diphtheria, measles, whooping-cough, chicken-pox, influenza, smallpox and malaria. I almost shudder when I pronounce these names, calling to mind, as I do, the disastrous consequences which so often follow in their wake. A child born in rural Maryland is to be congratulated if it reaches the age of young manhood or young womanhood. In the first place, it is probably ushered into the world by the aid of a midwife who possesses but little technical knowledge. So little attention is paid to the event that it is doubtful if an official record is made of its birth. If it lives through the perilous "second summer," it becomes legitimate prey to the tender mercies of the diseases of childhood.²³

²²In his healthy and perfect state, in the full meridian of his usefulness and vigor, "What a piece of work is a man!—how noble in reason! how infinite in faculties! in form and moving how express and admirable! in action, how like an angel; in comprehension, how like a god; the beauty of the world! the paragon of animals!"

²³"Constitutions are not made, but grow." In a "Dissertation Upon the Cholera Infantum: with Rules and Regulations As Preventive Means of the Autumnal Diseases of Children Which Gained the Boylstonian Prize for the Year 1803," written by Dr. James Mann, A.M., fellow of the Massachusetts Medical Society, there appears the following suggestive paragraph on pp. 27 and 28:

"Filth and dirt are supposed to be one cause of this disease. Under this article are included filthy habitations, dirty clothing, animal and vegetable substances in a state of decay. From the above sources, combined with heat and moisture, is formed an infectious state of atmosphere which disposes the human body to disease. What the characteristic principles of these subtle materials are which emanate from reservoirs of filth elude our researches. It is probable they may not be dissimilar to those offensive agents which are generated within the alimentary canal from acetous and putrid fermentation. These principles of infection most probably always exist in the common atmosphere, but become active only when they are in a concentrated state. This is one reason which may be offered why the inhabitants of close-settled cities and populous towns are more exposed to the scourges of disease than those of thinly-scattered villages. The fatal effects of an infectious atmosphere are already too well known by the annual epidemics which prevail in most of our large towns to require a circumstantial detail. Infants, who are the most susceptible, are generally the first victims of its morbid influence. These offensive materials have been variously denominated, according to what has been supposed their nature and origin, from which are obtained the names *morbific*, *effluvia*, *marsh miasmata*, *mephitic vapour*, *animalcule contagion*, *putrid fermentation*, *nitrous acid gas* or *septon*. The materials of expiration and perspiration, when they are suffered to be accumulated, are real poisons. These also, in such states, form spheres of infectious principles around the bodies from which they originate. As the most mortal forms of disease are supposed to have their existence from these causes, it may be literally said of the animal system, even in a state of health, that it is a storehouse of infection."

Is it surprising, then, that the "pale and sickly cast" should meet the experienced eye at almost every turn of the road? Scarlet fever leaves it with a running ear; measles, with weak lungs; diphtheria, with a weak heart, while severe attacks of whooping-cough, chicken-pox and influenza so lower its vitality that it is a wonder it survives at all.

All of these diseases can be prevented. Tuberculosis, the "White Plague," is especially a preventable disease. It is not hereditary, but arises from another case of tuberculosis, being transmitted chiefly by means of infected dust or infectious particles thrown off in the act of coughing.

What can the people in the rural districts do to ward off tuberculosis? In this State nearly 2500 deaths result annually from tuberculosis. More than half of these are in suburban and rural communities. In the entire State there are always nearly 10,000 persons ill with the disease.²⁴

In the first place, greater care should be taken in regard to expectoration. In rural communities, especially, consumptives expectorate on the sidewalks, pavements, railroad station platform, on the floors in public places, and even on the floors in the home. His handkerchief, teeming with tubercle bacilli, is drawn from his pocket and shaken over the dinner table or into the faces of the other members of the family. The same drinking-cup and eating utensils are used by the consumptive and others in the household. If a male, his beard and mustache are probably infected by coming in contact with the expectorated matter. Kissing the other members of the family, and even relatives, is practiced. His sleeping-room is never fumigated and rarely ventilated, and other members of the family occupy it with him. Taking into consideration the above conditions, is it any wonder that tuberculosis was formerly considered hereditary?

The part which rural communities can play in the suppression of tuberculosis can be summed up as follows:

- (1) Greater care in regard to expectoration.
- (2) Better personal hygiene and hygiene in the home.
- (3) A prompt registration of all tuberculous persons, so that the advice and co-operation of the local health officer and the State Board of Health can be secured.

But what shall I say about typhoid fever, sometimes called "drain fever," by reason of its frequent association with bad drainage? Typhoid fever is the bane of country life. The country place is its stronghold, and thence it is disseminated almost broadcast throughout the land. In the year 1911, in rural Maryland, 349 persons died of typhoid fever. These deaths comprised persons in the prime of young manhood and in the flower of young womanhood. In point of fact, typhoid fever almost invariably attacks persons in the prime of life.

²⁴Nearly a century ago Dr. James Blake wrote the following suggestive sentence: "Now I think we may conscientiously tell our consumptive patients that when living out in the mountain air they are doing far more to re-establish their health than anything we can do for them."

The following means and methods will aid very materially in preventing typhoid fever in rural districts:

- (1) The use of a pure drinking-water supply.
- (2) Protection against flies. The screening of houses is essential.
- (3) Supervision of the milk supply. Allow no one connected with a typhoid fever case to work about the dairy. Guard against washing the milk cans and other utensils with infected water.
- (4) Do not use so-called "night soil" on growing vegetables intended to be eaten raw, except in conformity with the regulations set forth by the State Board of Health.
- (5) Proper attention should be paid to sewage and drainage.²⁵ Observation has convinced me that sewage and drainage are very defective in most rural districts and in most country homes.
- (6) Careful disinfection of all typhoid discharges.
- (7) Prompt medical attendance in all suspected cases of typhoid fever.
- (8) A prompt reporting of all cases or suspected cases of typhoid fever to the local health officer. It is the duty of the attending physician to perform this service.
- (9) Guard against transmission of the disease by contagion or direct contact. This also applies to eating utensils, fever thermometers, etc.
- (10) Inoculation against typhoid fever. This is a means of preventing typhoid fever which has given good results, and it is within reach of all.

In regard to scarlet fever, it is fast becoming a rare disease. The following are the chief means of combating it:

- (1) Prompt isolation of cases or suspected cases of the disease.
- (2) A prompt reporting of such cases by the attending physician to the local Board of Health.
- (3) Terminal disinfection; that is, disinfection of the patient's room, clothing, etc., after recovery.²⁶

²⁵Dr. Charles Caldwell, on pp. 109 and 110 of his *Medical and Physical Memoirs, Containing Among Other Subjects a Particular Inquiry Into the Origin and Nature of the Late Pestilential Epidemics of the United States*, published in 1891, emphasizes the following as one of the ten causes which co-operate in the production of our autumnal epidemics, with especial reference to the city of Philadelphia:

"Dirty yards, cellars and privies. In a city as extensive and populous as Philadelphia these are sources of immense exhalation. They have been known to produce cases of yellow fever, even in the depth of winter, and must greatly increase our epidemics of summer and autumn. They should be subject to the inspection of officers of police, and when neglected their cleanliness should be enforced by the imposition of fines.

"Besides the influence of our privies in injuring the atmosphere by exhalation, they have also an effect in contaminating the waters of our pumps. These serve as an additional medium for conveying their poisonous particles into our systems, and are probably instrumental in the production of disease. Under the disadvantage of their present construction, I am sorry to observe that our privies constitute a nuisance not easily remedied."

²⁶The importance of terminal disinfection was early recognized by the College of Physicians of Philadelphia. In a Memorial published in 1798 entitled "Facts and Observations Relative to the Nature and Origin of the Pestilential Fever Which Prevailed in This City in 1793, 1797 and 1798," the following suggestive paragraph occurs on p. 10:

"The measures to be pursued for purifying the city from any latent infection are such as we have heretofore recommended, viz.: a strict attention to cleanliness, washing, whitewashing and ventilating the infected houses, bedding and clothing, and fumigating them with charcoal and sulphur or a mixture of oil of vitriol and saltpetre. These, with the frost, we believe, will be found sufficient entirely to destroy any latent contagion."

When I speak of diphtheria, I refer to a disease which medical science has practically conquered. Indeed, I might go so far as to say that *it is unnecessary for anyone to contract typhoid fever if he (or she) will submit to typhoid inoculation; and it is equally as unnecessary for a person to contract diphtheria if he (or she) will be immunized against it.* Unfortunately, in country districts especially, children still die of diphtheria even before the disease is recognized. Therefore, to protect the boys and girls,²⁷ the "hope of our country," I desire to formulate the following advice:

(1) Regard every case of suspicious sore throat as diphtheria until proven by culture to be otherwise.

(2) Isolate such a case at once, and send for your family physician.

Measles is a disease which is pretty hard to control. Many cases are mild, and a physician is not even summoned. Then, too, there is no serum or protective inoculation against measles. In stamping out this disease we have to rely largely upon—

(1) Isolation of all cases, whether mild or severe.

(2) A prompt reporting of every case, no matter how mild. If no physician has been called, this duty devolves upon the parents or householder.

(3) It would be well to disinfect after measles, but as the contagious principle in this disease is not very tenacious of life, disinfection is rarely done, certainly in rural districts.

While whooping-cough, chicken-pox and influenza are very contagious, even partial isolation of the patient and careful attention to the simple rules of cleanliness usually suffice to prevent their spread. All of these diseases, like the foregoing, are reportable.

Smallpox needs scarcely be mentioned, as there has not been a case in the State of Maryland so far this year. Vaccination is a sure preventive when danger from smallpox is imminent.

Malaria, commonly called "chills and fever" and "fever and ague," is another distinctly preventable disease. Screening the living-rooms, as well as the sleeping apartments, as should be done anyhow as a protection from flies, is very necessary; but it is better policy to destroy the breeding places of the mosquito, a certain variety of which transmits the parasite of malaria. Before the enunciation of the mosquito theory of the transmission of malaria by Dr. A. F. A. King of Washington, D. C., in the year 1882, country folks usually took the following precautions against malaria:

(1) They made it a rule to sleep in the second or third story,

²⁷It has been most truly said, "Man is not a mere producer, a mere machine. His life or death, his happiness or misery, is much too high an object upon which to place a pecuniary value. He is more nicely made, more wonderfully organized, requires to be guarded with more care from any influence that may surround him to produce disorganization and unfit him for use; is capable of higher and nobler purposes, and has a higher and nobler destiny, and in proportion as in each of these he exceeds a mere machine, in such proportion ought we to regard his intellectual and moral nature, and the means used to preserve and develop his physical powers, to enable him best to accomplish the great purpose of his existence."

believing that the "bad air" which caused malaria circulated low and circulated at night.

(2) They grew numerous sunflowers, beautiful and attractive in themselves, and believed to promote health.

(3) They planted the willow tree and the blue-gum tree, especially the first.

Undoubtedly much good was accomplished by these primitive methods, resorted to by rural folk in their early efforts to guard against malaria. For instance, mosquitoes are much more numerous on the first floor of a dwelling than in the upper stories. The sunflower extracts much moisture from the soil, thus aiding in the draining of marshy land, wherein the mosquito especially thrives; and the same salutary result is accomplished by the willow tree and the blue-gum tree, both of which absorb much moisture by means of numerous tiny rootlets, said moisture passing off from the leaves by evaporation.²⁸

VII. SEWAGE AND DRAINAGE.

I have now arrived to the last item in my paper—the problem of sewage and drainage. If any intelligent person were asked to name what he (or she) considers to be the most important questions now confronting the rural portion of our population, the answer would probably be as follows:

First, the migration of the inhabitants of the rural districts to the cities; largely a social and economic problem; and second, the question of sewage disposal and drainage.

The question of sewage and drainage constitutes the most important public health topic of the present day. This is essentially so in suburban districts and in rural communities. In no quarter of the globe has it become more markedly manifest than in the environs of the city of Baltimore.

Go to the average country home or rural community, and what do you see? We behold, with astonishment, the "two graces" in typhoid fever dissemination, namely, the surface toilet and the surface well, hugging one another almost as closely as the late

²⁸J. Disturnell, in his masterly volume, "Influence of Climate in North and South America," published in 1867, records the following interesting data, on pp. 181 and 182, under the caption, "Climate of the Middle States":

"The Middle States, lying southwest of New York, are comprised of New Jersey, Pennsylvania, Delaware and Maryland. Pennsylvania, extending the most northwardly, is bounded by 42 degrees N. Latitude, and Maryland, the most southwardly, is bounded by 38 degrees N. Latitude on its eastern limits. This section of country extends from the Atlantic Ocean to Lake Erie, on the western confines of Pennsylvania, 80 degrees 40 minutes W. Long. * * * The Allegheny range of mountains extend through Pennsylvania and Maryland, lowering the temperature in some elevated places very materially. * * * The southern section of the Middle States has a mean temperature of 58 degrees Fahr. The seasons are as follows: Spring, 58 degrees; summer, 76 degrees; autumn, 59 degrees; winter, 37 degrees. The southern portion of Maryland, lying on the Chesapeake Bay, is a level, sandy section of country, producing Indian corn, wheat, tobacco and sweet potatoes. The country here changes materially from that portion lying above Mason and Dixon's line, or the northern boundary of Maryland bordering on Pennsylvania. The average annual fall of rain in the Middle States is 40 inches, the largest quantity falling near the seaboard, or in the vicinity of Chesapeake and Delaware Bays. * * * Intermittent and other fevers prevail in the south-east part of this region, in the vicinity of Chesapeake Bay, while the climate found on the seashore from New Jersey to Virginia is celebrated for its health-restoring and invigorating qualities."

world-famous Siamese twins. If we tarry yet a little while we shall see myriads of house-flies, wending their way from the toilet to the kitchen and dining-room, not at all weighed down by a burden of some 600,000 disease germs each.

With such conditions staring us in the face, is it any wonder that the country home, or the farm, is called the stronghold of the deadly typhoid bacillus? Shall we continue to be amazed to observe that typhoid fever, dysentery, infantile diarrhoea and intestinal parasites are more prevalent in "fly time?"

The fly is not the only transgressor where the insanitary surface toilet exists. Poultry, swine and other domestic animals soon find the way thereto, and play a part in the work of destruction and death.

During a freshet the infectious material may be washed directly into a well unprotected from surface drainage. Or it seeps into the soil, eventually reaching the water-bearing strata. As typhoid germs have been known to live a year buried in the soil, it would be at least that long before the water drawn from an infected well would be safe for drinking purposes, even if the insanitary conditions were corrected.

The public drinking-cup has been abolished by law; and I am of the opinion that the surface toilet must also go if we desire to foster public health in the rural districts. Then we shall have destroyed one of the principal breeding places of flies, now recognized as so potent a factor in the dissemination of typhoid fever.

So long as the surface well is in use, it will continue to be a Goliath in the spread of typhoid fever. A public water supply of undoubted purity should be provided in all rural communities, while on the farm a driven well or an artesian well should be the rule. In a few instances a progressive farmer has sunk an artesian well, erected a wind pump and water tank, and equipped his home with a modern bathroom. I believe this movement will soon become general, and every up-to-date country home will eventually be provided with a pure and wholesome water supply, as well as every facility for bathing.

The drainage of many suburban places in Maryland is notoriously defective. There are none worse than some of those in the immediate vicinity of Baltimore. But Baltimore is not saying a word, because, although founded in 1720, the city itself is just now installing a sewerage system.

I believe the day will soon dawn when every city and incorporated town in the State of Maryland will have its sewerage system, and every well-regulated farm its sewage-disposal plant. Then the perplexing "night-soil" problem will have solved itself. Then, too, that dread scourge—typhoid fever—will be well-nigh eradicated; infantile diarrhoea will be almost stricken from the mortality roll, and intestinal parasites will be gazed upon as pathological curiosities in our medical museums. The last pair of

house-flies will have been tenderly stored away by Professor Uhler²⁹ in the museum of the Maryland Academy of Sciences, and generations yet unborn will gaze upon them in wonderment to think that their forefathers permitted such filth-loving, disease-bearing insects to dwell among them.

Too much credit cannot be given to the noble work done by the various civic leagues, women's clubs, men's clubs and similar organizations throughout the State in the cause of improved sanitation or physical betterment in urban, suburban and country life. The Women's Civic League of Baltimore may be exploited as one whose example is well worthy of emulation. Its members, never weary in well-doing, have achieved wonderful results, and their methods have been widely copied by other cities intent upon civic betterment.

VIII. CONCLUDING REMARKS.

The importance of rural sanitation cannot be overestimated. Upon it often hangs the health of an entire city, in addition to that of the rural community itself. City people, in fact, all classes and conditions of mankind, are dependent upon the farm and farm products. In the eloquent words of Daniel Webster, uttered in the year 1839:

"Agriculture feeds us; to a great degree it clothes us; without it we could not have manufactures, and we should not have commerce. These all stand together; but they stand together like pillars in a cluster, the largest in the center—and that largest is Agriculture."

To be a little more explicit, not one of you would care to purchase beef or milk from a farm upon which you knew tuberculosis prevailed among the cattle. You would not care to purchase milk from a farmer in whose family typhoid fever, scarlet fever or diphtheria prevailed. Spareribs or pork chops would not be half so toothsome if you knew they came from a herd of swine decimated by hog cholera or swine plague. Beefsteak and onions could not be eaten with as much relish if you knew that one or more of the "four great bovine scourges"—pleuropneumonia, rinderpest, foot-and-mouth disease and tuberculosis—prevailed among the cattle, or that the onions had been fertilized with so-called "night soil." As a matter of fact, unless you thought the sanitary condition of the farm was reasonably good, you would seek elsewhere for the necessities of life.

Just 400 years ago Ponce de Leon sought to discover the "fountain of perpetual youth," and lost his life in the attempt. It is half a century since Brown-Sequard announced that he had discovered the real "elixir of life." But these and all similar attempts have proven futile, and the best that we can do is to lead

²⁹Philip Reese Uhler, LL.D., born in Baltimore, June 3, 1825. A well-known entomologist: formerly assistant to Prof. Louis Agassiz. For a number of years he has been president of the Maryland Academy of Sciences and associate in natural history at the Johns Hopkins University. Until recently he was provost and librarian of the Peabody Institute. He is now entirely blind and in feeble health.

the simple life in order to round out the full measure of our days.³⁰ According to Mrs. Osgood, "Labor is rest";³¹ and simple industry is oftentimes the keynote to physical as well as worldly success.

In the course of my remarks I have dwelt largely upon infectious diseases and vital statistics, or the "bookkeeping of humanity."³² The importance of these subjects in rural sanitation or physical betterment in country life cannot be sufficiently emphasized. The diseases of infancy and childhood, especially those common to school children, are far-reaching in importance—facts which are now being brought forth in a clearer light by the noble work of our school inspectors. Inspection of schools, however,

³⁰The following classical statements appear in an introductory lecture to the course of theory and practice of medicine in the medical department of Pennsylvania College, delivered October 14, 1856, by Dr. Alfred Stillé, and entitled "The Unity of Medicine":

"The only certain event in life is Death. Sooner or later a sickness befalls every one which no vigor of constitution can withstand, and which no physician's skill can cure. All other illnesses spare the life, and are led to a favorable issue by natural strength or by art, or by both of these united. Thus we perceive there is one direction in which nature opposes an impassable barrier to human power: that there is one hour in which knowledge, experience and devotion are all in vain. But we cannot tell at what period of life the supreme summons shall arrive. * * *

"* * * In spite of hygienic rules, or owing to their neglect, it is certain that diseases abound. They beset the path of life from its commencement to its close, attacking the germ in the womb, blasting the blossoming hopes of childhood, prostrating man in his pride and power and cutting down the hoary head upon the verge of the grave. No wonder that it should have been one of the earliest of human efforts to find the means of mitigating the pains of sickness and of averting death."

³¹Mrs. Frances Sargent Osgood, American poetess, born, 1811; died, 1850. The full stanza is:

"Labor is rest—from the sorrows that greet us;
Rest from all petty vexations that meet us,
Rest from sin-promptings that ever entreat us,
Rest from world-sirens that lure us to ill.
Work—and pure slumbers shall wait on thy pillow;
Work—thou shalt ride over Care's coming bilow;
Lie not down wearied 'neath Woe's weeping willow!
Work with a stout heart and resolute will!"

³²The annual address before the Medical Society of the County of Albany, New York, delivered on November 8, 1859, by Dr. Sylvester D. Willard, president of the society, was entitled "The Importance of Mortuary Statistics." In it is found the following paragraph, on pp. 10 and 11:

"Disease has lessened in some portions of the city (Albany, N. Y.) at least one-third—I speak without figures—and there has been, I apprehend, a corresponding diminution in mortuary results, effected by the introduction of a full supply of pure water; but in nothing are the interests of Albany more neglected than in its sanitary measures. It has no medical police. Its Board of Health has no vitality. The laws of health are grossly violated. Slaughter-houses are allowed within the city limits, and every wind blows the foul odor of their unabated nuisances over our population. There is no sufficient regulation for the removal of garbage. Privy vaults are allowed to remain reeking with filth and exhaling sickening effluvia. Stagnant water evaporates in some of our streets. Ponds, in which are cast dead bodies of every description, from horses to still-born children, are left undrained; and not unfrequently the carcasses of dead animals putrefy and rot in the streets unremoved. Our most public thoroughfares are made filthy by the daily droves of cattle and swine. Cellars, dark, damp and unventilated, are inhabited. Stables in the most disgusting condition are on our very borders. From all these and other sources the poisoned miasma arises and settles upon our unguarded people. They die and are buried, and no mortuary statistics remain to warn others against these evils. The body politic may shrink from such testimony, but it is true, and their laws do not interpose to prevent and make it otherwise."

should not be restricted to our larger cities, but should penetrate to even the remotest country districts.³³

Many infectious diseases find access into the bodies of school children by way of the mucous membrane of the nose and mouth, and also by way of the tonsils. In fact, these three—nasal mucous membrane, buccal mucous membrane and tonsils—constitute the most important "portals of entry" for the infectious agents causing diphtheria, measles, scarlet fever, pneumonia, epidemic cerebro-spinal meningitis, and probably infantile paralysis. Therefore, it is of paramount importance that school children should be inspected, and diseased conditions of the upper air passages, such as adenoids, enlarged tonsils, chronic catarrh, etc., be promptly treated by a competent physician.

Ventilation of country homes, as well as of schoolrooms and all public places, should receive greater attention. Fresh air and sunshine, Nature's best disinfectants, are readily accessible to all. Few country homes can be properly ventilated, because the windows can rarely be lowered from the top.

"All men desire to live long, but no man would be old,"³⁴ is a sentence which I parsed in the grammar school 25 years ago. But a great writer has said, "We live in deeds, not years,"³⁵ and that mysterious essence which we call life has been defined as "the sum total of forces by means of which we resist death." There are foes from within³⁶ and foes from without. We may acquire

³³The following paragraphs occur at the close of an admirable pamphlet entitled "Hints Respecting the Chlorosis of Boarding Schools," written by the author of "Hints Respecting the Distresses of the Poor," and published in London in 1795:

"Unfortunately, schools that have arisen to reputation soon become too crowded with inmates for the advantages of health. On entering a schoolroom crowded with children a very unpleasant smell and heated air disgusts a person coming from the fresh air: this foul air tends to enfeeble the children, relaxes the frame and renders it susceptible of cold and disease; and hence all schoolrooms should be furnished with ventilators placed low in the room, and there should be air holes considerably above to allow the rarefied air to escape while fresh air is supplied by the ventilators.

"These cursory hints I now refer to the consideration of the public, being persuaded that, were the management of children regulated by them, chlorosis would rarely occur: nor would sore throats and low fevers so often thin and almost annihilate schools near the metropolis. I have seen the issue of whole families swept away by their fatality; and, if the hints suggested shall preserve any individual from this melancholy catastrophe, I shall not have written in vain."

³⁴Dr. John Gardner, in his volume entitled "Longevity: the Means of Prolonging Life After Middle Age," published in 1875, advances the following summary of his views concerning old age on p. 155:

"Ageing is a result of the operation of several concurring causes. Mere lapse of time will produce it. But ageing does not synchronize with age; that is, with the number of years a life has continued. In some persons it begins earlier, and in others later.

"Ageing consists in molecular changes proceeding in all the textures and organs of the body, involving a deterioration, degradation or a species of decay. It may exist without suffering or consciousness of the change. A person may say, and truly, 'I am quite well for an old man, or an old woman.' The qualification implies that there is some degree of weakness, some departure of power formerly enjoyed, and the tendency is daily toward more and more debility."

³⁵"We live in deeds, not years; in thoughts, not breaths:

In feelings, not in figures on a dial.

We should count time by heart-throbs. He most lives

Who thinks most, feels the noblest, acts the best."

³⁶The colon bacillus may be cited as a typical example of a "foe from within": likewise the pneumococcus. The former is a normal inhabitant of the intestinal tract of man and warm-blooded animals; the latter, according to Netter's observations, is found in the mouths of 20 per cent. of healthy persons. But let the intestinal canal become deranged, and the colon bacillus is liable to cause appendicitis. Or let the lungs become congested and their vitality below par, and the pneumococcus is prone to bring about an attack of pneumonia.

tuberculosis from our brother-man. The house-fly may give us typhoid fever; the cat, scarlet fever and diphtheria; the dog, tape-worms and other intestinal parasites, while the rat may transmit to us bubonic plague.

But I have detained you long enough. I thank you, one and all, for your unfaltering attention. In conclusion, I desire to quote an editorial, full of wit and humor, yet not totally devoid of scientific truth. It is entitled "The Danger of Being Alive," and reads as follows:

"Drink water and get typhoid fever. Drink milk and get tuberculosis. Drink whiskey and get the jim-jams. Eat soup and get Bright's disease. Eat meat and encourage apoplexy. Eat oysters and acquire toxemia. Eat vegetables and weaken the system. Eat dessert and take to paresis. Smoke cigarettes and die early. Smoke cigars and get catarrh. Drink coffee and obtain nervous prostration. Drink wine and get the gout. In order to be entirely healthy, one must eat nothing, drink nothing, smoke nothing, and even before breathing one should make sure that the air has been properly sterilized."

THE BLOOD OF THE FATHERS. A Play in Four Acts. By G. Frank Lydston. Chicago: The Riverton Press. 1912. Published by subscription only.

Medical sociology has become well established as a separate division of the medical sciences and is demanding the best thought of many of the medical leaders. In order to more firmly impress the laity, as well as the profession, with the penalty posterity has to pay for the crimes of its fathers, Dr. G. Frank Lydston has written the above four-act drama on hereditary criminology with the conviction that he will thereby more impressively focus the public attention upon the necessity of regulating marriage between the physically and criminally unfit. In the play he expounds the doctrine of castration of those unworthy of becoming fathers either as a result of criminal natures or physical unfitness. Dr. Lydston's wide experience in observation of the ill results of the transmission of hereditary taints has led him to this belief, and he takes the drama as the best method of conveying his ideas on as well as impressing the people with the importance of the subject. As the country is each year feeling more and more the burden of taking care of its degenerates and criminals, it is high time that a method of control be instituted. If the little drama, "The Blood of the Fathers," which is well written, can arouse sufficient interest to awaken the public to the urgency of devising ways and means of combating the evil of marriages which are prone to be followed by a still further propagation of the criminal class, Lydston may look upon himself as a human benefactor of the first water. At any rate, we congratulate the author upon his audacity in attacking a social system which all thinking people know to exist, but many haven't the courage to fight.

WHAT'S THE MATTER?

*To the Chairmen and Secretaries of the Different Sections
of the Medical and Chirurgical Faculty of Maryland:*

Gentlemen—In the State of Maryland, according to Polk's Medical Directory, 1910, there are 2051 physicians. Of that number 1158 are registered in Baltimore city, leaving a balance of 893, representing the number of physicians in the counties of Maryland. There are 1017 members of the Medical and Chirurgical Faculty. Of this number 515 are residents of Baltimore city and 502 are residents of the counties of Maryland, and are, if you please, country doctors and general physicians. Now, a problem in arithmetic presents itself. Subtract 1158 from 2051 and we have 893 as a remainder, and represents the number of physicians in the counties. Divide 502, the number of physicians in the counties of Maryland who are members of the Medical and Chirurgical Faculty, by 893, the number of physicians in the counties of Maryland, and we have .56, the percentage (56 per cent.) of county physicians who are members of the State association. I am very much under the impression that there is a small number of the county physicians of Maryland who are members of their county medical society, but are not members of the State Faculty. Divide 515, the number of members of the Medical and Chirurgical Faculty of the City of Baltimore, by 1158, the number of physicians in the city of Baltimore, and we have .44, the percentage (44 per cent.) of city physicians who are members of the State association. These figures show that, although there are more physicians in the city of Baltimore than in the counties of Maryland, there is more interest shown by the county members, judging by their membership in the State Faculty by 12 per cent., than by the physicians of Baltimore city.

Attending the different sections of the Medical and Chirurgical Faculty, one is impressed at the small number of physicians present and the lack of interest taken. The chairmen and secretaries of the different sections seem to forget; and have overlooked the number of physicians in the new belt which has been formed and is extending around the city of Baltimore. In Anne Arundel county there are 26 physicians who are members of the State Faculty; in Baltimore county there are 69 members; in Harford county there are 18 members; in Howard county there are 13 members. In addition to these, there is a percentage of men who are not members of the State Faculty who might become so if a little attention was shown them. Many of these physicians would be glad to receive a postal card notifying them of the meetings of the different sections of the Medical and Chirurgical Faculty and to have the opportunity of attending these meetings. Physicians living within an hour's ride of Baltimore city would be well repaid for the time taken and the expense incurred in hearing a well-written, well-read paper before any one of these sections. Would

it not be well for the officers to take this matter into consideration before the first meeting of their several sections, arranging to open all meetings promptly at the hour mentioned on the card and closing them at no later than 10 P. M.; and notify the county members, who, as indicated by the figures mentioned above and by their memberships, are intensely interested in the advancement of medicine?

WILLIAM J. TODD.

Mt. Washington, Md., October 15, 1912.

Book Reviews.

ARTERIOSCLEROSIS. Etiology, Pathology, Diagnosis, Prognosis, Prophylaxis and Treatment. With a Special Chapter on Blood Pressure. By Louis M. Warfield, A.B., M.D., Assistant Superintendent and Resident Physician to Milwaukee County Hospital; Assistant Professor of Medicine, Wisconsin College of Physicians and Surgeons, Milwaukee, Wis.; Formerly Medical House Officer, Johns Hopkins Hospital, Baltimore, Md.; Member American Medical Association. Second edition, revised. With an introduction by W. S. Thayer, M.D., Professor of Clinical Medicine, Johns Hopkins University. Illustrated with 28 engravings. St. Louis: C. V. Mosby Company. Cloth, \$2.50 net. 1912.

Only when the medical profession comes to the realization that more people are carried off by heart and arterial affections than by either cancer or tuberculosis can the victims of arteriosclerosis expect to receive scientific treatment. Surgeons have long since arrived at the conclusion to get the best results they must operate at the incipency of the disease when the patient is in good condition, otherwise the operation may be of no benefit and thus throw surgery into disrepute. The same tenet holds true in arteriosclerosis. If anything is to be accomplished by the physician, he must get the case early; in fact, according to the dictates of some, before obvious hardening of the vessels. Therefore, any light which can be thrown on the subject owing to the universal prevalence of the malady is opportune, and meets a distinct need, as the literature on this subject heretofore has been scattered and hard to obtain. The above is one of the most valuable books recently published, and possesses superior merit. It cannot help but exert a distinct influence in bringing about a better understanding of arteriosclerosis. Besides a thorough account of the anatomy, pathology, physiology of the blood circulation and blood pressure, etiology, the physical examination of the heart and arteries, symptoms and physical signs (both general and special), prognosis and diagnosis, it contains chapters on prophylaxis, practical suggestions, treatment and arteriosclerosis in its relation to life insurance. The writer lays especial emphasis upon the prevention of senile changes in the arterial walls. He bewails the present mode of life which burns the

candle at both ends (the high pressure under which we work), as a mental strain is a powerful influence in the production of the bodily changes under discussion. He advises, therefore, people with great mental responsibilities to take moderate outdoor physical exercise if they hope to keep their arteries healthy. He emphasizes also the importance of the physician regulating the course of life of heavy eaters and drinkers, and especially so if these habits are combined with concentrated brain work. Only in this way, he states, is the prophylaxis of arteriosclerosis possible.

The treatment is along rational lines, but would have been more scientific if the author had taken into consideration the intake and output of nitrogen; also the amount of urea contained in the blood. Certainly in feeding arteriosclerotics one must determine what the kidneys can do, and this result can only be arrived at by an exact knowledge of what the patient is eating, the amount of urea in the blood and the amount of urea eliminated daily by the kidneys.

The above is not a criticism, merely a suggestion; and is only offered for what it is worth, as work is constantly being done along these lines and has apparently simplified feeding in kidney affections. Warfield is to be congratulated on the excellence of his contribution, which is concise, well expressed and exceptionally meritorious.

MAKING GOOD ON PRIVATE DUTY. Practical Hints to Graduate Nurses. By Harriet Camp Lounsberry, R.N., President West Virginia State Nurses' Association; Sanitary School Inspector for Charleston Independent School District. Philadelphia and London: J. B. Lippincott Company. 1912. Cloth, \$1 net.

Trained nurses have become a necessary institution in these times. Indeed, the successful termination of many ills is dependent upon skilful nursing alone. The physician is entirely aware of the aid to be derived from the employment of a skilful nurse and is cognizant of her indispensability. Therefore any hints which tend toward increased efficiency of the nursing profession—and no one will deny that it can be improved—are indeed timely. The employment of a trained nurse is a serious proposition, not only as it affects the internal rearrangement of the house, but also the respect and honor of two professions. Nurses have it in their power to be an agent of good or bad, and are in a position to make the life of their employers (afflicted family and doctor) miserable or pleasant. Nothing in the experience of a physician is more annoying than an unsatisfactory nurse. First, and above all, the nurse owes implicit loyalty to the physician employing her. It is not for her to say whether the treatment is right or not. She must remember that medicine is not an exact science, and that there are more ways than one in many instances of arriving at the

same end, that there is a constant flux and flow of ideas concerning the proper method of handling a certain affliction, and that the treatment with which she is acquainted, though accepted today, may be discredited tomorrow. It is her duty to carry out the instructions of her employer, and those alone. If the treatment does not meet with her approbation, and she cannot conscientiously give it, she has the privilege of relinquishing the case, but she must not discredit the physician in the eyes of his patient. It is this power of turning the patient and his family against the doctor, who has in many instances given years of good and faithful service, that makes a doctor hesitate about calling in a trained nurse.

The author lays especial emphasis upon the fact that the nurse is the doctor's aid and occupied in an entirely different field of endeavor. She especially notes the importance of loyalty to the physician to get the best results. If this idea could be indelibly impressed upon every new graduate, there would be less friction and more confidence between the two professions.

The writer also throws out many hints concerning the relation which should exist between the nurse and her patient. Good advice, and advice which, if followed, would render the thorny path of nursing less hard to traverse. Space is also devoted to the nurse and her patient's family, friends and servants; why do nurses complain; some hints for the obstetrical nurse; general remarks on foods and feeding, etc. The volume is replete with homely advice, and which should be read by every nurse, both undergraduate and graduate. Open the pages wherever you may, there you will find something worth while reading. The beauty of the book is that it does not have to be read through, but can be read with instruction and pleasure for a minute or so, depending upon the time at your disposal, wherever opened.

MASSAGE AND THE ORIGINAL SWEDISH MOVEMENTS. Their Application to Various Diseases of the Body. Lectures Before the Training School for Nurses Connected with the Hospital of the University of Pennsylvania, German Hospital, Woman's Hospital, Philadelphia Lying-in Charity Hospital, the Philadelphia Polyclinic and College for Graduates in Medicine, and the Kensington Hospital for Women of Philadelphia. By Kurre W. Ostrom, from the Royal University of Upsala, Sweden. Seventh edition, revised and enlarged. With 115 illustrations. Philadelphia: P. Blakiston's Son & Co. 1912. Cloth, \$1 net.

The tendency of modern medicine is to get away from medicines and back to nature; therefore any book which uses its influence in this direction should be welcomed by physicians. It is needless to say that American doctors are only too poorly grounded in the science of massage; consequently a contribution from the pen of such an authority as Ostrom should be of immense value in exactly defining just what can and cannot be

expected of massage in the treatment of disease. The book gives a very concise exposition of exercise in therapeutics, massage as a therapeutic agent, pressing and shaking (vibrations), details of treatment, contraindications for massage, Swedish movements, positions, divisions of movements, the physiology of the movement treatment, mechanical action of muscles, application of massage, etc., to various diseases of the body, etc. Anybody interested in massage will find in the present work many helpful suggestions as well as intensely interesting reading.

THE PRACTICE OF OBSTETRICS. Designed for the Use of Students and Practitioners of Medicine. By J. Clifton Edgar, Professor of Obstetrics and Clinical Midwifery in the Cornell University Medical College; Visiting Obstetrician to Bellevue Hospital, New York City; Surgeon to the Manhattan Maternity and Dispensary; Consulting Obstetrician to the New York Maternity and Jewish Maternity Hospitals. Fourth edition, revised. With 1316 illustrations, including 5 colored plates and 36 figures printed in colors. Philadelphia: P. Blakiston's Son & Company. 1913. Cloth, \$6 net.

Edgar's *Obstetric* has become so endeared to the medical student that there is really no need of a critical review of a new edition, as everybody is fully acquainted with its merits. Ever since its first appearance it has taken a prominent position in the student library, and we predict that this, the last edition, will retain the prestige and popularity of its predecessors. Among the notable additions to the text are observations on blood pressure, anesthesia in labor, vaccine and serum treatment of sepsis, hemorrhage of the newly born, pelvimetry of the pelvic outlet, funnel pelvis and their treatment, premature rupture of the membranes, pubiotomy, extraperitoneal Cesarean section and the Momburg belt constriction for hemorrhage. Besides the above additions, wherever necessary the text has been completely revised. Especially has the author found it necessary to rewrite the pathology of the various subjects. We are glad to note that the author in speaking concerning the choice of an anesthetic for obstetric operations lays down the rule which should govern the choice of an anesthetic under any other circumstance; namely, that ether is the safer and should be preferred; especially is this the case in puerperal eclampsia, because chloroform tends to produce necrosis of the liver cells and thereby increases the toxemia. His warning that because chloroform is the more convenient it should not be allowed to enter into the consideration of the choice is, indeed, timely, as well as the injunction, no question of convenience should be allowed to interfere with the safety of the patient. In regard to the treatment of puerperal infection by vaccines, the author states he has thoroughly tried them and found them wanting. He also states that the value of the opsonic index in these cases is questionable. The above conclusions have

been reached by about everybody else. The writer, however, recommends the use of a polyvalent serum, prepared under the directions of Dr. William H. Park of the New York Board of Health, as he has experienced encouraging results from its use: results that so he states cannot be ignored.

For thoroughness, completeness and simplicity of diction Edgar's *Obstetrics* is surpassed by none and equaled by few of its competitors. As heretofore, the student or general practitioner of medicine contemplating the purchase of an obstetrical assistant of the first water will be more than satisfied with the fourth edition of the above-mentioned volume.

HYPNOSIS AND SUGGESTION. Their Nature, Action, Importance and Position Amongst Therapeutic Agents. By W. Hilger, M.D. (of Magdeburg). Translated by R. W. Felkin, M.D., F.R.S.E. With an Introduction by Van Renterghem, M.D. (Amsterdam). Translated by A. Newbold. New York: Rebman Company. 1912. Cloth, \$2.50 net.

Though hypnotism therapeutically is upon a well-established base, one hardly conceives that as late as 1860 was first advanced the idea of hypnosis for therapeutic effect, and that the discovery was so ridiculed that no respectable physician would have anything to do with the new art. It was not until 1878, when Charcot put his stamp of approval upon the method, and admitted that, after all, there was something in it, that hypnotism was accorded the reception due it. Since then hypnosis has been continually broadening its field therapeutically through the efforts of a host of enthusiastic investigators. It is with hypnosis as applied to medicine that Hilger's book deals. All sensational claims are laid aside, and the author in simple, scientific style tells what may be expected of this agent. Undoubtedly too little attention is paid by the medical schools to physical therapeutics. The entire medical profession will benefit materially when it is brought to realize that there is some good in these aids. It is such books as Hilger's that will awaken the profession to their importance.

THE SURGICAL CLINICS OF JOHN B. MURPHY, M.D., AT MERCY HOSPITAL, CHICAGO, OCTOBER, 1912. Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London. Volume I, Number 5. Baltimore: The Medical Standard Book Co. Paper, \$8 per year.

The value of Murphy's Clinics to the operating surgeon has become so well established that it is superfluous at this late day to sing their praise. One cannot but help realize that a permanent record of the work of such a man as John B. Murphy is a privilege which the medical profession will only thoroughly appreciate when the laborer has been called to his reward. There is only one criticism which we can offer to the volumes which have so far appeared; that is, the articles seem unfinished. One is left with the

impression that Doctor Murphy does not supervise the reporters' notes, but lets them go out as recorded. This is a minor matter, but if corrected would add greatly to the finish of each volume. As in the preceding numbers, so here, a wide range of subjects is covered; all of which are of interest to the practical surgeon. Amongst the most interesting sections are those on bone operations. It is in this field as much as any other that Doctor Murphy is acknowledged the foremost exponent in America. Consequently his observations and conclusions are of the utmost importance to the surgical world.

A TEXTBOOK OF OBSTETRICS, INCLUDING RELATED GYNECOLOGIC OPERATIONS. By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania, Gynecologist to the Howard, Orthopedic and Philadelphia Hospitals, etc. Seventh edition. Revised and enlarged, with 895 illustrations, 53 of them in colors. Octavo of 1013 pages. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1912. Cloth, \$5 net; half morocco, \$6.50 net.

Hirst's Obstetrics has been on the market too long to need any encomiums from the reviewer. For six editions, one after the other, it has met most admirably the demands of both students and practitioners, and has today become recognized as a standard volume. Such being the case, it is hardly to be expected that the present edition will fall in the estimation of those employing it as a textbook. In obstetrics, as in other lines of medical effort, constant advances are being made, and what is authoritative today is obsolete tomorrow. Therefore, the life of any book on midwifery is soon run, unless the author brings it up-to-date. With the idea in view of making his production of the greatest use to the greatest number, he has found it necessary to again revise his former editions, and now presents to the profession the latest, the seventh edition, for which we predict greater success than any of its predecessors. In this volume, the physiology of the process of generation precedes the pathology, which undoubtedly is a more logical sequence. A most noteworthy and excellent feature of the present as well as the past volumes is the inclusion of sections on diseases of women. Such should be the case in every textbook on obstetrics, as by far the vast majority of women diseases is the penalty of childbearing. An additional attraction which adds to the merit of the present presentation is the addition of a chapter on diseases of the breast. The number and excellence of the illustrations cannot help but call forth the commendation of the medical fraternity. It is our opinion that Hirst's obstetrics, as heretofore, will more than meet the most critical demands of an exacting profession.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, DECEMBER, 1912

DR. FRANKLIN BUCHANAN SMITH.

THE axiom, "Death ever loves a shining mark," is particularly appropriate in the case of Dr. Franklin Buchanan Smith of Frederick, a man endowed with the highest qualities of mind and character and highly esteemed by the profession and those among whom he labored. He was tried as by fire and not found wanting. His geniality and attainments made it possible for him to be the recipient of many honors from the hands of his brother physicians, in which trusts he always acquitted himself with credit. Under his directorship the Medical and Chirurgical Faculty prospered as never before, and by his death has lost a steadfast and loyal servant. Those who knew him will always consider it an honor to have been numbered amongst his friends. Though taken away from us in his prime, his influence will continue to be with us. Deeply religious and ready to meet the call of his Master, as a true soldier he met death without a qualm. He made himself greatly beloved in his community by performing his duty without murmur or complaint. In the shadow of death a few well-selected words from his lips have enabled many a soul to pass over the Great River more resignedly, and to those who remained he had ever a word of encouragement and sympathy. He led an active professional life and took a leading part in each and every movement which tended to the uplift of his profession, and exemplified by his life the high possibilities of a country doctor's life. Endowed with a handsome face and magnificent physique, he was a marked figure wherever he happened to be. Added to these favors of nature, he had the courtly manners, dignity, ease and grace of a true Southern gentleman. He was an old-school doctor in the

broadest sense. He was extremely modest and devoid of all vanity. Dr. Smith was born April 10, 1856, in Frederick, Md. His primary education was obtained at the Frederick Academy, Frederick, Md. He then matriculated at Princeton University, from which institution he received the degree of B.A. with the class of 1876, and M.A. three years later. His medical education was acquired at the University of Pennsylvania, graduating M.D. in 1878. Immediately after leaving college he settled in Frederick,



DR. FRANKLIN BUCHANAN SMITH

where he lived and practiced his profession until his death; serving as health officer of Frederick, 1886-1895; vice-president Maryland State Board of Medical Examiners; president Frederick County Medical Society, 1900-1903; president Association of Surgeons of the Baltimore & Ohio Railroad, 1900; member of the United States Pension Board for Frederick county for 10 years; vice-president of the Medical and Chirurgical Faculty of Maryland, 1903-1904; president Medical and Chirurgical Faculty of Maryland, 1910-1911.

Medical Items.

THE following resolutions were adopted and ordered spread on the minutes by the Anne Arundel County Medical Society, at the regular meeting held at Annapolis, Md., Tuesday, October 8, 1912:

Resolved, Whereas God in his infinite wisdom has chosen to remove from our midst our friend and fellow-practitioner of medicine, Dr. H. Roland Walton.

Resolved, That the Anne Arundel County Medical Society extend the family of our deceased friend and fellow-practitioner, Dr. H. Roland Walton, their heartfelt sympathy in their hour of affliction.

Resolved, That a copy of these resolutions be forwarded to the family of the late Dr. H. Roland Walton.

Resolved, That a copy of these resolutions be published in the official organ of the Medical and Chirurgical Faculty of Maryland.

Resolved, That a copy of these resolutions be published in the MARYLAND MEDICAL JOURNAL.

Resolved, That these resolutions be entered upon the minutes of this meeting held the eighth day of October, 1912.

Respectfully,

LOUIS B. HENKEL, JR.,
Secretary.

THE engagement of Miss Caroline Estelle Lauer, daughter of Mrs. Henry Lauer of Walbrook, to Dr. Elijah Emara Nichols, University of Maryland, '11, of Pikesville, Md. The wedding will take place in the early spring.

DR. RICHARD C. CABOT was a recent visitor to the Hopkins and University Hospitals.

DR. KARL HENRY VAN NORMAN, formerly of the sanatorium of the Tuberculosis League of Pittsburgh, and Dr. Ralph B. Seem, formerly superintendent of the James Walker Memorial Hospital of Wilmington, N. C., have been appointed assistant superintendents in Johns Hopkins Hospital, and together with Dr. Rupert Norton, they will assist Dr. Winford H. Smith in his work of governing the hospital.

DR. ISAAC DICKSON, who has been very ill with peritonitis, has sufficiently recovered to resume his practice.

DR. WILLIAM TARUN, who has been in the Adirondacks for some time for his health, is sufficiently recovered to resume his practice.

ACADEMIC Day was observed at the University November 12, and marked the one-hundred and twenty-third anniversary of the founding of the department of arts and sciences, St. John's College, and a gift of \$5,000 was announced from Dr. and Mrs. J. C. Hemmeter for the department of physiology.

DR. JOHN C. HARRIS is seriously ill, suffering from a stroke of paralysis. He is 74 years of age.

THE Baltimore and Ohio Railroad will build an emergency ward at the Maryland University Hospital at a cost of about \$5,000.

DR. RANDOLPH WINSLOW was given a surprise dinner at the University Hospital on the occasion of his sixtieth birthday.

DR. WILLIAM F. WEGGE, formerly of Baltimore, and a graduate of the University of Maryland, was one of the alienists appointed to investigate into the sanity of John Shrank, the assailant of Ex-President Roosevelt.

DR. CHARLES G. HILL was injured by being struck by an automobile, but is much improved.

DR. HENRY W. KENNARD has been appointed assistant superintendent of the School for the Feeble-Minded at Owings Mills.

THE Harriet Lane Home for Invalid Children was formally opened November 7.

DR. SAMUEL T. NICHOLSON has been appointed superintendent of the Sydenham Hospital, vice Dr. Josephus O. Wright, resigned. Dr. Nicholson has been in hospital work in Missouri for a year and is 26 years of age.

THE engagement is announced of Miss Emma Victoria Horn of Mount Airy, Md., daughter of Mrs. Ernest B. Horn, to Dr.

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THE following officers were elected at the quarterly meeting of the Washington County Medical Association held in Hagerstown, November 14, 1912: President, Dr. V. M. Reichard of Fairfax; vice-president, Dr. Daniel A. Watkins of Hagerstown; secretary, Dr. W. D. Campbell of Hagerstown; treasurer, Dr. J. Royer Laughlin of Hagerstown. The retiring president, Dr. Samuel M. Wagaman, made an address. Dr. Daniel A. Watkins reported a case of invaginated appendix. Dr. J. McPherson Scott was elected a member of the board of censors and Dr. V. M. Reichard was elected a member of the hospital board.

DR. PAUL BROWN is located at Pennsylvania avenue and Robert street, Baltimore.

DR. J. D. DICKERSON of Stockton was elected president and Dr. J. L. Riley of Snow Hill secretary-treasurer of the Worcester County Medical Society.

THE Hecht Memorial Nurses' Home at the Hebrew Hospital will be formally opened December 9.

MRS. HENRY THOMAS LEWIS of Greensboro, Ga., has announced the engagement of her daughter, Anna, to Dr. Arthur de Talma Valk, Johns Hopkins Medical School, '10, of Annapolis.

DRS. HUGH H. YOUNG, Randolph Winslow, Alexius McGlannan, Howard A. Kelly, C. F. Burnham, J. C. Bloodgood, L. F. Barker, B. M. Bernheim, J. M. T. Finney, W. S. Baer, A. C. Harrison, T. B. Futcher, T. R. Brown, W. S. Halsted, J. Staige Davis, Rhoades Fayerweather, H. E. Ashbury and John W. Chambers were among the Baltimore physicians who participated in the meeting of the Interurban Orthopedic Club, which met in Baltimore, November 18 and 19. Drs. Baer and Fayerweather of Baltimore are members of the Association.

DR. LLOYD PARKER SHIPPEN, who was taken ill with pneumonia while on his wedding trip, has recovered.

DR. HOWARD A. KELLY is working actively in the crusade against the social evil in Baltimore and other cities.

W. B. SAUNDERS & Co., medical publishers, are now established in their new building on West Washington Square, Philadelphia, Pa.

MARRIAGES.

THOMAS PALMER TREADWAY, M.D., Johns Hopkins Medical School, '10, of Erie, Pa., to Miss Caroline Buffington of Baltimore, at Baltimore, November 12, 1912.

WILLIAM DEFOREST OLMSTEAD, Baltimore Medical College, '03, to Mrs. Bessie T. Ijams, both of Baltimore, at Baltimore, November 14, 1912.

ROBERT PAGE COOKE, M.D., University of Virginia, '97, of Front Royal, Va., to Miss Nellie Virginia Jones of Westminster, Va., at Front Royal, November 1.

HENRY PICKERING PARKER, M.D., Johns Hopkins Medical School, '01, to Miss Eleanor Cullom Ridgeley, both of Washington, at Washington, November 22, 1912.

DEATHS.

JOHN DENHAM PALMER, M.D., University of Maryland, '72, of Jacksonville, Fla., died in St. Luke's Hospital in that city from the effects of an accidental gunshot wound November 3, 1912, aged 62 years.

FRANKLIN BUCHANAN SMITH, M.D., University of Pennsylvania, '78, died at his home in Frederick, Md., November 5, 1912, from typhoid fever, aged 56 years.

CHARLES HICKS, M.D., University of Maryland, '77, died at his home in Mount Vernon, Ga., October 31, 1912, aged 58 years.

ALEXANDER TINSLEY, M.D., New York University Medical College, '67, died at his home in Baltimore Saturday, November 16, 1912, aged 90 years.

HEZEKIAH W. FAIR, M.D., Hahnemann Medical College, '80, died at his home in Baltimore November 15, 1912, aged 63 years.

EDWARD J. KIEPE, M.D., Johns Hopkins Medical School, '97, of Buffalo, N. Y., died at Kansas City, Mo., as a result of poison self-administered, aged 45 years.

MARYLAND Medical Journal

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ACTION OF THE TROPICAL SUN.

Medical Record.

THERE are many who hold that white men succumb more or less quickly to the climate of the tropics, or if they do not die they deteriorate physically and mentally, and that, in short, the inhabitant of the temperate zone is not physically adapted for a tropical life. These views would seem to have been borne out by experience, and yet there are some who contend that if the white man will only live with an eye open to the dangers of his surroundings and a care to shun them he may live in the tropics in fair health for the greater part of his life. In the *Philippine Journal of Science* appeared recently a paper by Hans Aron setting forth a series of experiments undertaken in the Physiological Laboratory of the College of Medicine and Surgery at Manila for the purpose of investigating the action of the tropical sun on men and animals.

The conclusions reached as a result of these investigations were interesting and valuable. These were as follows: (1) Under climatic conditions, even during the cooler seasons of the year in Manila, animals, such as rabbits and monkeys, which by nature have only a limited power of physical heat regulation, or animals the physical heat regulation of which is artificially inhibited, die if exposed to the sun, the body temperature rising to febrile heights. If the same animals are protected from the rays of the sun, or if the increase of heat due to radiation from the sun is compensated by an increased loss, such as would be brought by a strong wind, then the animals suffer no discomfort. Insolation of the skull alone is without effect if the body temperature is kept within normal limits. (2) The post-mortem examination of animals dying as a result of insolation shows decided hemorrhagic lesions of the brain and in monkeys of the heart. (3) In animals without sweat glands the subcutaneous tissues are heated by the radiated heat from the sun to temperatures above those compatible with life. (4) The human skin, if exposed to the sun, is warmed to about 3° or 4° above the normal skin temperature. An increase even to the normal body temperature is prevented by evaporation of sweat. The cooling effect of the sweat secretion causes a fall of the skin temperature even if insolation is continued during longer periods. (5) The brown skin of the Malays, while theoretically absorbing more heat in the sun, shows a smaller rise of temperature in the tropical sun than the skin of white men under similar conditions. As an explanation, it is believed that an earlier and greater evaporation by sweat secretion takes place. (6) The air in the human hair, especially in black hair, under the influence of the tropical sun, acquires a high temperature. (7) It is demonstrated that in the tropical sun a man with a colored skin is in a better position as regards heat regulation than is a man with a white skin.

It is pointed out that the monkey is a denizen of the woods, and instinctively avoids the sun. The same is true of the native of the tropics, if he is left to his own customs. Consequently, the argument is somewhat thus: A white man is not so well fitted by nature for tropical life as his colored brother. Outside the tropical diseases, for the most part carried by insects and avoidable by taking due precautions, the chief menace to the white man of a trop-

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TO

Medical Advertisements

PAGE II

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The manner in which the purest and freshest cod-liver oil is emulsified in Hydroleine, makes it easily digestible. Furthermore, Hydroleine does not offend the taste. Its nutty and distinctive flavor is liked by the most delicate palate, and children take it willingly.

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THIS PREPARATION is more generally and extensively used to subdue the above conditions than all other remedies combined. These troublesome and torturing symptoms of many skin affections are usually the first to require attention, and a remedy that will meet this indication is indeed a God-send to both Physician and Patient. ECZEMA, HERPES, ERYTHEMA, TINIA, DERMATITIS, caused by Poison Ivy or other irritant, can be cured more promptly with RESINOL than any other treatment. It is also a superior and satisfactory dressing for BURNS, SORES, CHAFING, EXCORIATIONS, and ABRASIONS OF THE SKIN.

Resinol Soap, while being a Medicated Soap, is a most delightful Bath and Skin Soap. Its use promotes skin health and effectually prevents infection. It keeps the scalp free of dandruff and the complexion clear of eruptions, etc.

Resinol Ointment, Resinol Toilet Soap, and Resinol Medicated Shaving Stick represent the best of their class

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SAMPLES ON REQUEST

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ical climate is the sun. Therefore, in order to live in health in the tropics a white man should avoid exposure to the sun, especially in the interior, where the mitigating effects of the normal sea breeze are not experienced.

IS THE OLD MAN WORTH SAVING?

American Medicine.

IS THE old man worth saving? Economically he may be almost, if not entirely, worthless, from an esthetic viewpoint his appearance may be disagreeable, if not absolutely repellant, his idiosyncrasies may make him disliked and a trial to those who must associate with him, while his inability to accommodate himself to the progressive order of the day often entails difficult tasks upon those who look after his welfare. Yet humanity says he is a human being with the right to live and enjoy the blessings of life; sympathy says he is helpless and needs aid; gratitude says he has served mankind in one capacity or another while he was able, now mankind owes it to him to take care of him, make him happy and prolong his life. This applies as well to the physician as to the rest of mankind.

There is no string to the physician's self-imposed obligation to relieve distress wherever he may find it, and prolong life, however valueless such life may be. He may not shirk these obligations toward the aged because of the hopelessness of ultimate success, nor because his patients have idiosyncrasies, nor because his labors in other fields would be more profitable. His obligations toward humanity demand that he give to the aged the same knowledge, the same skill and care that he gives to the child and adult. If he obeys the demand of humanity alone to save and prolong the life of the absolute idiot, how much more readily and willingly should he obey the demands of humanity when joined by sympathy and gratitude, in favor of the aged. The old man has an intense desire to live, yet nothing detracts so much from his pleasure of living as the pains and discomforts that accompany old age. He looks to the physician to relieve him of his ailments and prolong his life. The physician who has neglected the study of geriatrics confesses to himself his inexcusable ignorance of senility and its diseases, while sympathy urges him to do something for the old man. He does something. It has all the chance of a guess. A right guess, and he brings happiness to a grateful old man. A wrong guess, and his mistake is buried in the grave of his victim. This is the humanitarian aspect of geriatrics.

Geriatrics presents two other aspects as clearly defined as the humanitarian aspect. The scientific aspect involves problems as interesting, possibly as important, as any in the whole realm of medicine. There is a practical side involving the prolongation and increase of the usefulness of the individual in the declining period of life.

Why do we age? Is there any controllable factor in the cause or process of involution? Is it possible to defer senility or restore vigor to the senile organism through artificial means? These are momentous problems. They bear upon the human race. They have engaged the minds of the most profound scientists and medical investigators for ages. Brown-Sequard's announcement of his elixir which would prolong life aroused world-wide interest, which continued for years after the unfortunate results of treat-

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Monosodium-Diethyl-Barbituric Acid

A freely soluble hypnotic for use by mouth, by rectum and subcutaneously. Being readily absorbed and rapidly excreted, it is distinguished by

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SOPORIFIC EFFECT**

**FREEDOM FROM CUMULATIVE
TOXIC ACTIONS**

Superior to the sparingly soluble diethyl-barbituric acid of Mering. Advantageously replaces chloral in threatening delirium tremens; useful in the treatment of morphinism.

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Combines the action of valerian with that of bromine, but is readily taken and well borne, causing no eructation or other untoward symptoms. Exhibits

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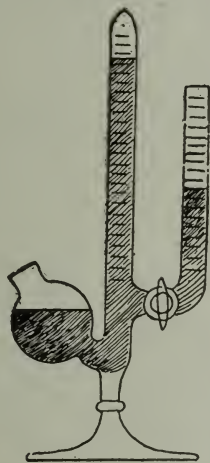
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Dose: 1 to 3 pearls several times daily

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ment destroyed faith in his remedy. Metchnikoff's theory is still under discussion, while his remedy is being employed throughout the civilized world.

Of more direct and immediate interest to the physician dealing with the aged are the causes and nature of the so-called diseases of metabolism which prevail mostly in advanced life. There is nothing unreasonable in the view that diabetes, gout, chronic rheumatism and even cancer are due to some perversion in the process of involution; that in the case of cancer the normal degenerative process in the affected tissue is interfered with, while in the other diseases the fault lies in the catabolic processes. But whether we determine the underlying causes of aging or not, it is certain that a more thorough knowledge of the anatomical and physiological changes in old age will cause us to change our views concerning the diseases of that period. "Cazallis' overworked aphorism needs only the element of truth to make it a medical axiom." The arteriosclerosis of old age is a physiological condition, while arteriosclerosis in maturity is often a curable disease. The senile contracted kidney is not interstitial nephritis, nor is the senile contracted liver cirrhosis. These and other senile conditions can only be learned by a scientific study of senility. This is the scientific aspect of geriatrics.

The material aspect of this branch of medicine can be dismissed in a few words. Enough has been said to show the importance of geriatrics, but it must receive the recognition of the medical profession before the public can be made to understand its importance. It is a poor field for commercialism or self-exploitation; it is a rich field for scientific study and humanitarian effort. To the physician who is imbued with the spirit of scientific research, geriatrics opens up a world of possibilities. Sympathy is rewarded by a gratitude that only the aged to whom a new lease of life is granted can show. Nor is the field entirely barren to those who seek more material returns for their labors. With the recognition of its importance and the development of its possibilities, when the verdict of "old age" ceases to carry with it an inevitable death warrant, and instead hold out a hope for temporary usefulness, it is more than probable that geriatrics will then take its place among the most important branches of medicine. In the meantime, let us encourage the pioneers who are blazing the way and building the foundation of the new science.

Fordham University has the distinction of being the first institution of learning to have a course devoted to the study of the diseases or disorders of old age—geriatrics, as it has been termed. Dr. J. L. Nascher, a New York physician who deserves great credit for crystallizing the matter and organizing the department, is, as far as we know, the only lecturer in the world on the subject. The whole movement and every one connected therewith deserve great commendation, and Fordham University is to be congratulated on the spirit of progress which has led to the establishment of a course that is bound to prove so important as soon as the world grasps its possibilities.

THE IMPORTANCE OF EXERCISE.

American Medicine.

THE importance of exercise as a factor in the preservation of health was never more broadly appreciated than it is today. The

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For many years we have made strong claims regarding the advantage of maltose—the predominating carbohydrate in Mellin's Food—in infant feeding. Physicians who have not made use of Mellin's Food in the modification of milk will find much to substantiate our claims by reviewing recent pediatric literature. The unvarying amount of maltose as given in the analysis* of Mellin's Food enables the physician to so modify milk that any percentage of this carbohydrate, best suited to the needs of the individual infant, may be readily obtained.

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is especially valuable when there is torpidity of the bowels or intestinal sluggishness arising from organic derangement of the liver and kidneys. It is the best agent for the relief of that form of constiveness that is ushered in by an attack of colic and indigestion, and not only clears away the effete and irritating matter in the alimentary tract but eliminates the semi-inspissated bile that too frequently induces the so-called "bilious" condition; at the same time an abundant secretion of normal bile is assured, thereby demonstrating its value as a liver stimulant and true cholagogue.

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truth of this is amply corroborated by the large number of special systems that are being exploited in the advertising pages of our popular magazines. Taking advantage of the widespread recognition of the harm that results from lack of proper exercise, the opportunists have offered a multitude of methods, freaky, fakey and otherwise, for developing the muscles, the breathing capacity, and general physical powers of the body, all with a minimum of effort but a maximum of result. "Spend five minutes every morning with Dr. T's dumb-bell drill—and insure your health." "Use Professor B's patent exerciser five minutes every morning—and watch your muscles grow!" "Follow Professor A's original system of opposing groups of muscles—and become a Sando!"

And so it has gone. Countless people, conscious of the need of more exercise, have grasped at these special systems as a drowning man grasps at a straw. Lazy and lethargic as the average person of sedentary habits always is, the hope of accomplishing so much at so slight an expenditure of time and effort has been attractive indeed. It certainly is a delightful picture that the corpulent and obese have had conjured by these advertisements of the exercise specialists. Who would not spend five or ten minutes a day performing even the most outlandish capers in the secrecy of their rooms—and the freedom of their pajamas—if they could exchange rotundity and unsightly proportions for the physique and beautiful development of an Apollo or an Adonis? Possibly a few have received some benefit from these "get-strong-quick" systems, for the slightest increase of muscular effort, however simple it may be, is a gain if on no other basis than that a little is better than none. But in the great majority of instances, after a few days' listless endeavor, the "wonder-working" system is discarded and the individual begins the search again for some other plan or process that will bring the desired results more promptly or with still less expenditure of actual effort. Sooner or later these patients run the whole gamut of freak exercises for the lazy, and become more lethargic than ever. Physicians are usually consulted at this time when those who most need exercise are least willing to take it in any form. Aside from the actual muscular inertia, the psychic state of those addicted to sedentary or torpid lives leads them to regard any routine or systematic scheme of physical exercise with the greatest antipathy. Of all hardships, systematic exercise seems, therefore, to be the worst for this class of people. As a consequence, they go on "digging their graves with their teeth," and storing up in their bodies poisons that are bound to curtail their years of life. Zealous physicians, recognizing the evils that inevitably result from insufficient physical activity, have long sought a solution of the problem. Gymnasiums, indoor and outdoor, have been helpful to many, and still further benefits have accrued from such games as baseball, football, hockey, tennis, squash, handball and so on. The great drawback to these games, however, has been the fact that they all require special skill, and gradually those who play them are narrowed down to those who show special aptitude. Those who really need to play them most, avoid them because their physical weaknesses or muscular shortcomings render them inefficient and awkward. These games, as a matter of fact, are largely responsible for the failure of many to exercise sufficiently, for only a few can acquire real prowess, and it is the line of least resistance to watch those who are expert, and leave actual playing to them. Horseback riding is another excellent

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THE UTILIZATION OF WOOD WASTE BY DISTILLATION A general consideration of the **NEW INDUSTRY**, including a full description of the distilling apparatus used and the principle involved; also methods of chemical control and disposal of the products; first edition, illustrated by 74 engravings; 456 pages. This book is cloth-bound. It will be sent to any address, postpaid, on receipt of \$4.20.

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¶ The secret of the production of this industrial alcohol in chunks is very simple and cheap. You can have it for a very small consideration. Can be made cheaply at home and sold in drug stores with good profits. A sample can containing twenty-six solid alcohol cubes, with a stove for burning same, will be sent to any address, postpaid, on receipt of **\$2.00**.

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exercise for those whose circumstances and opportunities admit of a pastime or sport that is obviously exceedingly expensive.

Unquestionably an exercise, to admit of universal application, must be simple, call for no special apparatus, equipment or individual skill or ability, admit of wide variation to meet the needs or capacity of different people, and finally afford a degree of muscular activity that will insure the benefits sought. The exercise that seems to meet these various requirements most satisfactorily is walking.

DISEASES CURED OR IMPROVED BY COLD AIR.

American Medicine.

DISEASES cured or improved by cold air are evidently much more numerous than we have hitherto imagined. Malaria is particularly benefited, even if not cured, and it relapses by return of hot weather—facts long known as to tuberculosis, dysentery and other intestinal cases. Ross and Thomson report that their animals were far livelier, healthier and more vigorous in the cold, and it fully explains the curative results in Trudeau's classical experiments with tuberculous animals treated outdoors, for the sunshine had nothing to do with the laboratory cases in Liverpool, as the room was but indifferently lighted. Crane long ago (*St. Louis Medical Review*, July 7, 1906) showed that cold air is beneficial in human tetanus, and that experiments indicate that guinea pigs infected may not develop the disease in cold air, but hot air hastens the appearance of symptoms. Our former sad record of Fourth of July cases shows it is a hot weather disease, and now we see it is not only due to the fact that the organisms then grow in garden mold, but that the children are more susceptible. Cold air in yellow fever has been both suggested and condemned, and must be further studied. All in all, there is no doubt that we must spend as much money cooling the sick rooms and living rooms in summer as we spend warming them in winter; indeed, it is far more important to cool them, for we can live in cold houses by dressing for it, like millions of people of other nations do. As for therapy, cold air is now as necessary as quinine or mercury, and every hospital must be equipped. In a short time it will be a mere routine as to prescribing the degree of cold to be maintained in the ward, and it will then be done by the turn of a valve without altering the ventilation in the least.

The reasons why cold air is curative have not yet been discovered. The only thing we know is the fact of cure, but our ignorance must not delay the application of the new knowledge. We haven't the remotest conception of how quinine cures, but we do not hesitate to use it. The main fact known, and about the only one, indeed, is the contraction of superficial arterioles—a condition extending also to those of the mucous surfaces whose inflamed condition often disappears miraculously. Skin lesions indirectly due to heat are largely the direct result of capillary dilatation, and disappear with cold, of course. Cold air has more oxygen and requires fewer respirations and less heart energy, both of which are vital matters where the heart is laboring. More blood is available internally if the superficial system is partly empty, and this of itself may cure inflammations or stop infections. An anemic person makes his blood more effective and indeed we may actually need less in the cold than in the heat. The bracing effect of cold on the

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By reason of its marked analgesic, anti-spasmodic, expectorant and inflammation-allaying properties, Glyco-Heroin (Smith) is of exceptional value in the treatment of

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The adult dose of the preparation is one dram, repeated every two or three hours. For children of more than three years of age, from five to ten minims.

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nervous system is known, but why this happens is a mystery, unless the tissue is better fed by the increased blood supply. It is largely a racial matter that intellectual achievements come from cold climates, but these same types become sluggish in time when they migrate to hot places, so the heat is nervously depressive in some way. Indeed, the whole field is fascinating in its opportunities for research. Why not get at it as vigorously as we have been studying the bugs and vaccines?

The blood pressure in cold air must be studied at once, as it may be the key to much which is now locked from us. The arterial tension is generally reduced at first when one goes to high altitudes, but it is later increased, as a rule, and this may be due to the cold, and not a reaction from a low barometric pressure which really has no mechanical effect on the blood pressure. It has long been known that the heart is weak, and the blood pressure low, as a rule, in tuberculosis, and if we can increase both by cold we have one explanation for the winter cures and a hint for climatic treatment. It begins to look as though places with a hot season and those with no cold season will in time be ruled out for the tuberculous. The death rate at some of these places has been scandalous, and in spite of rose-tinted reports of those interested financially and commercially, there is reason to believe that many a consumptive has had his life greatly shortened by going to a hot climate. If lowered blood pressure really results from the heat, we have the explanation.

INVESTIGATION OF SPRUE.

Medical Record.

THE suggestion is said to have been made recently by some British observers that there was sufficient resemblance between sprue and pellagra to warrant the surmise that they might be one and the same disease. It is very unlikely that there will be found to be more than a superficial resemblance between the two affections. Nevertheless, the report from Great Britain that a thorough investigation of sprue is to be undertaken, arouses the hope that our knowledge of this disease will be enlarged. Sprue, or psilosis, is a troublesome and serious affection which may last for years, producing great emaciation and weakness from the persistent diarrhea which is nearly always an accompanying feature. Manson describes it as an "insidious, chronic, remitting inflammation of the whole or part of the mucous membrane of the alimentary canal. It occurs principally in adult Europeans who have resided in warm climates, and is chiefly met with in Ceylon, the Straits Settlements, Java, parts of China, Manila, and occasionally elsewhere. Its origin is unknown, although believed to be bacterial. The Ceylon Government has offered the London School of Tropical Medicine a sum of \$3750 to investigate, and it is expected that a further sum of \$1250 will be provided by the Ceylon Tea Planters' Association. Definite arrangements have not yet been made as to who will conduct this investigation, but the mere fact that the investigation is to be undertaken by a member of the London School of Tropical Medicine is in itself an earnest that faithful work will be done. Perhaps the etiology of yet another of the diseases which render tropical climates so harmful to the health of the white man will be discovered and a means of treatment or prevention evolved which will nullify its potentialities for evil.

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NATIONAL MEDICAL MEETINGS, 1911

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	Atlantic City, June, 1912
" Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1911
" Army and Navy Medical Association..	E. P. Bartlett, Springfield, Ill.....	
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	
" Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York..	
" Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists....	H. C. Ernst, Harvard Medical School, Boston..	
" Assn. of Railway Surgeons.....	Louis J. Mitchell, 67 Wabash Ave., Chicago....	
" Medical Temperance Association.....	T. D. Crothers, M.D., Hartford, Conn.....	
" Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo....	
" Assn. of Official Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill..	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	June, 1912
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York....	St. Louis, June, 1912
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	Baltimore, May, 1912
" Larynx, Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago....	Atlantic City, June, 1912
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	May 28-31, '12
" Medical Colleges, Association of.....	F. C. Zappfe, 1764 Lexington St., Chicago, Ill..	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia....	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	Hot Springs, Va., May 29-31, '12
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C....	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
" Public Health Association.....	William C. Woodward, Washington, D. C.....	Havana, Cuba, Dec. 4-9, '11
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass..	
" Surgical Association.....	Robt. G. Le Conte, 1536 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
Assn. Med. Officers A. and N. of Confederacy	A. A. Lyon, M.D., Nashville, Tenn.....	
Balto. & Ohio Assn. of Railway Surgeons..	T. A. Murphy B. & O. Bldg., Baltimore, Md..	
British Medical Association.....	Guy Ellison, London, England.....	
Canadian Medical Association.....	George Elliott, M.D., Toronto, Canada.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	
International Congress on Tuberculosis..	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	Rome, 1911
Mississippi Valley Medical Association....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky....	
Missouri Valley Medical Society of the....	Chas. Wood Fassett, St. Joseph, Mo.....	Colfax, Ia., March 21-22, '12
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Sulter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis..	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	May, 1912
Pan-American Congress, Fifth.....	Dr. Ramon Guiteras.....	
Seaboard Medical Assn. of Va. and N. C....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association....	L. C. Morris, M.D., Birmingham, Ala.....	Washington, Dec. 12-14, '11
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville, Tenn.....	
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn..	A. T. Mann, M.D., Minneapolis, Minn.....	Kansas City, Dec. 18-19, '11

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Dr. Charles E. de M. Sajous,

SUPERVISING EDITOR OF THE NEW YORK MEDICAL JOURNAL.

WE have the honor to announce that beginning with issue of December 9, 1911, Dr. Charles E. de M. Sajous of Philadelphia becomes the supervising editor of the *New York Medical Journal*. While Dr. Sajous will give up his private visiting practice, he will continue his work as a consulting physician, investigator, teacher and author, and thus be in a position to keep in the closest touch with the needs of the medical profession.

Though born under the American flag, Dr. Sajous received his preliminary education in France. He studied medicine in Philadelphia, graduating with honors from the Jefferson Medical College in 1878. He served for two years as resident physician in the Howard Hospital, and in 1881 was appointed professor of anatomy and physiology in the Wagner Institute of Science, lecturer in the Philadelphia School of Anatomy, and clinical assistant in the laryngological department of Jefferson Medical College, succeeding Dr. J. Solis-Cohen, in 1883, as clinical lecturer and chief of that department. In 1891 Dr. Sajous went to Paris, where he devoted six years to original research. Upon his return he was appointed dean of the Medico-Chirurgical College. At the recent reorganization of the medical department of Temple University Dr. Sajous accepted the

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chair of pharmacology and therapeutics, which he still holds.

The immediate outcome of Dr. Sajous' six years of research work in Paris was the publication of two volumes on *Internal Secretions* and the *Principles of Medicine*, a work which gave the author high standing as an original investigator.

Dr. Sajous has had a wide editorial experience, having founded in 1888 the *Annual of the Universal Medical Sciences*, which he conducted with the collaboration of some of the most eminent physicians in America and Europe, until the publication was abandoned in 1893. The *Annual* had a circulation of over 500,000 volumes, and the *Cyclopedia of Practical Medicine*, founded by Dr. Sajous in 1893 to succeed the *Annual*, and intended more particularly for the general practitioner, has attained a circulation of 240,000 volumes, the seventh edition being now in course of preparation.

The value of Dr. Sajous' services to medical science has been recognized in France by his being made a member of the Legion of Honor, while in Belgium he received the order of Leopold, and was made a Knight Commander

of the Liberator, besides receiving other titles, both governmental and scientific. In America Dr. Sajous has been president and vice-president of many societies, and is a fellow of the College of Physicians of Philadelphia and of the American Philosophical Society. He brings to bear on the editorial problems of the *New York Medical Journal* a brilliant and well-informed mind, wide experience and a thorough knowledge of the needs of the American physician.

The publishers of the *New York Medical Journal* feel that they, as well as its readers, are to be congratulated upon having obtained the services of Dr. Sajous. Comprehensive and well-directed plans have been formulated for enhancing the value and interest of the *New York Medical Journal*, and in carrying out these plans no pains or expense will be spared to give our readers a medical journal of unprecedented authority and interest.

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methods of compounding prescriptions in many drug shops has served as a warning to physicians. A sense of increased responsibility rests with the profession which should not be necessary.

Diagnosis and medical care in diseased conditions is a small part of a doctor's duty today. He must now see that the druggist uses pure ingredients in exact quantity as called for, in order to get desired results. The labors of Hercules read like play compared to this task. Only united efforts of honest druggists, physicians and the press persistently carried on will create and enforce legislation which must hark back to the manufacturer and wholesale drug supply sources. Substitution and adulteration have undoubtedly caused thousands of fatalities for which "inexact medical knowledge" or "ignorance and experiments of the doctor" have been blamed.

False labels on noxious and useless mixtures, accompanied by fraudulent literature, have deceived both physicians and laity. Some of the best-known and widely-accepted ready-to-take remedies are the most fraudulent. Of this class are the so-called cod-liver preparations. This fact was brought forward at the medical convention in Baltimore last spring, and analysis of several are on file in the laboratories of highest repute.

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THE Hormones and Hormone-Therapy, especially the Peristaltic Hormone of Zuelzer, known as Hormonal, a specific physiological therapeutic agent in chronic constipation, intestinal atony and the post-operative forms of intestinal paresis, are subjects at present in the very foreground of interest.

Schering & Glatz, New York, have published a 40-page brochure entitled "Hormone Therapy with Special Reference to Hormonal (Peristaltic Hormone—Zuelzer)," of which they will be pleased to mail a copy to every physician who makes request for the same.

THE C. V. Mosby Company of St. Louis has announced the publication of a book on Pellagra, to be ready by January 1, 1912. This book is being prepared by Dr. Stewart R. Roberts of Atlanta, Ga., who has just returned from Italy, where he studied the disease in its natural habitat. While in Europe the doctor made extensive research regarding the etiology and treatment of Pellagra, and the data contained in the book will reflect the latest and best work that has been done in connection with this disease, making it a reliable guide to those seeking information on the subject.

MARYLAND Medical Journal

Medicine and Surgery



The Medical Journal Company

BALTIMORE

Publishers

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Volume Fifty-Five
Number Two

FEBRUARY, 1912

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Announcement.

THE American Red Cross desires again to invite attention to the exhibition in connection with the Ninth International Red Cross Conference, which will be held in Washington, D. C., from May 7 to 17, 1912.

The exhibition will be divided into two sections, which will be styled Marie Feodorovna and General. The former is a prize competition, with prizes aggregating 18,000 rubles, or approximately \$9000, divided into nine prizes—one of 6000 rubles, approximately \$3000; two of 3000 rubles each and six of 1000 rubles each.

The subjects of this competition are as follows:

1. A scheme for the removal of wounded from the battlefield with the minimum number of stretcher-bearers.

2. Portable (surgeons') washstands, for use in the field.

3. The best method of packing dressings for use at first aid and dressing stations.

4. Wheeled stretchers.

5. Transport of stretchers on muleback.

6. Easily folding portable stretchers.

7. Transport of the wounded between warships and hospital ships and the coast.

8. The best method of heating railway cars by a system independent of steam from the locomotive.

9. The best model of portable Roentgen apparatus, permitting utilization of X-rays on the battlefield and at first-aid stations.

The maximum prize will be awarded to the best exhibit, irrespective of the subject, and so on.

The general exhibit is again divided into two parts; the first will be an exhibition by the various Red Cross Associations of the world. The second will be devoted to exhibits by individuals or business houses of any articles having to do with the amelioration of the sufferings of sick and wounded in war which are not covered by the Marie Feodorovna Prize Competition for the year. While the American Red Cross will be glad to have any articles pertaining to medical and surgical practice in the field, it is especially anxious to secure a full exhibit relating to preventive measures in campaign. Such articles will be classified as follows:

1. Apparatus for furnishing good water in the field.

2. Field apparatus for the disposal of wastes.

3. Shelter, such as portable huts, tents and the like, for hospital purposes.

4. Transport apparatus (to prevent the suffering of sick and wounded) exclusive of such apparatus as specified for the Marie Feodorovna Prize Competition.

As with the Marie Feodorovna Prize Competition, for this country only articles having the approval of the Central Committee of the American Red Cross will be accepted.

Diplomas will be awarded for exhibits in this section of the exhibition as approved and recommended by the jury.

Further information may be obtained from the chairman, Exhibition Committee, American Red Cross, Washington, D. C.

It is perhaps to apparatus having to do with prevention of disease in armies that the energies of Americans have been specially directed since the Spanish-American War. Therefore, the last-mentioned section of the exhibition should make an appeal to them.

INDEX

TO

Medical Advertisements

PAGE II

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Editorial Comment.

A PREMONITORY SIGN OF ACUTE INFECTIOUS DISEASES.

Medical Record.

ANY addition to the diagnostic resources of the clinic is to be welcomed, particularly in the case of the acute infectious diseases of childhood, in which an early diagnosis is a prerequisite to efficient isolation and prophylaxis. As yet there has been no means of recognizing these individually or even as a group during the period of incubation. Giovanni da Gaetani Giunta, in the *Archiv für Kinderheilkunde*, Vol. LVI, Nos. 4 to 6, reports that he has observed a symptom in some of the above diseases, even in earliest childhood, and at a period in the disease when there is no functional disturbance and before there are any demonstrable lesions. This premonitory sign consists in a swelling of the lymphatic glands of the axilla, neck and groin, which is present during the incubation period of measles, scarlet fever, chicken-pox, mumps, diphtheria and whooping-cough. The study of a large number of cases showed that in earliest childhood the lymphatic glands in the above-mentioned regions are ordinarily not palpable, but under the influence of various morbid agents they undergo the following changes: They are absolutely insensitive, both on spontaneous or passive movement; they present a variety of forms, in the majority of cases attaining the size of a lentil; they are most palpable and movable in the inguinal region. There is no marked correspondence between the axillary, cervical and inguinal glands. The presence of this form of glandular enlargement may, according to the author, be regarded as a certain premonitory sign of an acute infectious disease. Neither age nor sex has any bearing on the occurrence of this symptom, nor does this vary with the variety of disease present. The presence of this sign depends upon neither inherited nor acquired predisposition. The sign does not indicate the severity of the infection or the degree of resistance in the patient.

The period of incubation of the infectious diseases has been termed by Royer the "silent period;" but, according to Giunta, this stage of the evolution of these diseases is one of marked activity, involving important functional and physical changes in the lymphatic glands. These act as a barrier to the invading micro-organisms and their toxins. Not only do they serve as organs of inhibition and filtration, but they also elaborate the leucocytes, and therefore play an important rôle in the fight of the entire body against the most diverse infections.

This function is a complicated one, is always exercised, but with each new infection is aroused to increased activity. Moreover, the toxic substances produced in the various parenchymatous organs during the initial activity of the infecting agents cannot fail to affect the lymphatic apparatus. The latter is therefore the seat of numerous and profound changes in its inner workings, which as yet have escaped the searching eyes of science. The enlargement that accompanies these changes during the period of incubation of an infectious disease is not, however, a constant phenomenon. When present it may be the result of a lymphatic hyperfunction caused by functional changes in innervation, or of a more greatly developed reactive power of the glands with re-



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spect to toxic influences. There is a third possibility, namely, the glands may be the seat of a permanent latent microbic infection which predisposes them to added infection and hence to enlargement. This latter possibility, however, is not regarded by the author as of any moment in the production of his premonitory symptom of infectious disease.

SAND-FLY FEVER.

American Medicine.

SAND-FLY FEVER is another group now definitely separated from the class of simple continued fevers of unknown cause. This particular infection has been known in the hot, dry season of warm climates for over a century, but its connection with an insect was not known until Doerr discovered it in 1908. An interesting review of the literature and experiments has been published by Lieutenant-Colonel C. Birt, R. A. M. C., (*Brit. Med. Jour.*, September 24, 1910), from which one gathers a very distinct impression that this widespread short fever, which by the way, is sometimes quite sharp and accompanied by digestive disturbances and diarrhea, is also present in America in summer, particularly in the hotter places. There is no mortality, and it is exactly such a disease as we are prone to put down to a "touch o' the sun," indigestion, a touch of malaria, or even a "threatened typhoid." We therefore should be on the lookout for the tiny insect, *phlebotomus papatasi*, or its cousins, and perhaps we may save some patients a lot of unnecessary dosing. The infective organism has escaped notice so far, and it really may be ultra-microscopic, as it seems to pass through fine filters, but it may be big enough to see when we know how to stain it. There is a suggestion that it is a normal or pathologic parasite of some lower animal, and only accidentally present in man's blood, where it promptly perishes.

THE HORSE AND THE AUTOMOBILE.

Medical Record.

DR. WALTER LINDLEY of Los Angeles and 24 California physicians discuss in the *Southern California Practitioner* of October, 1911, the inferiority of the horse to the automobile from the hygienic point of view. At the recent California State Board examination Dr. Lindley asked, as one of the questions in hygiene: What are the hygienic advantages of the automobile over the horse at home and in the street? Naturally, from 24 medical men a large number of points of superiority of the automobile over the horse were given. Within the limits of an editorial article there is no space to note more than the general trend of these answers. Of course, the menace of horse manure was the feature chiefly dwelt on, and this menace, mainly in connection with manure as a breeding place for flies. Pollution of wells from stables was mentioned. The horse as the disseminator of the tetanus bacillus was referred to, also the danger of horses communicating glanders, the possibility of actinomycosis being communicated by the horse, etc. Several answers laid stress upon the fact that additional air and sunshine were enjoyed by those who had automobiles.

It would be interesting to learn from a company of medical men in what respects they might consider the horse superior to the automobile from the hygienic standpoint. No doubt the horse is a

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menace to health to a certain extent in a city, chiefly by reason of his stable affording a breeding place for flies. On the other hand, the automobile in a city has to answer for the promotion of more noise than was the case before its advent. This, too, affects the general population, perhaps, more than the motorist himself. Whether the automobile has increased nervous complaints to an appreciable degree is a moot point. There is, also, the question of dust dissemination to be considered when discussing the automobile. From the esthetic point of view there is room for comparison, but even from the hygienic standpoint solely the lover of the horse and the votary of the motor car would, doubtless, argue stoutly with regard to the relative merits of the animal and of the machine, and each would give cogent reasons for his attitude. Apart from the question of hygiene, however, the superiority of the machine over the horse, so far as the physician is concerned, is so marked and so proved by experience that it is probable no consideration will ever bring back the animal to the service of medicine except as a provider of antitoxins.

American Medicine.

FEE-DIVIDING has by no means been confined to the impecunious or lowly members of the profession. That the evil has been fastening its tentacles on some of the leading physicians and surgeons of the land has been well known for some time. Of especial significance is the recent discussion of the subject by the Erie County Medical Society, and still more recently the resolutions passed by the New York Academy of Medicine. When a body whose membership is as carefully chosen as this last-named organization finds it necessary to condemn an evil openly and notify its members that evidence of its practice will lead to expulsion, there can be little doubt that the situation has become serious. Within the past two months we have had offered to us by an investigator who has been studying the medical commission evil a mass of sworn evidence that was astounding. The affidavits, something like 80 all told, covered actual occurrences in Chicago, New York City, Buffalo, St. Louis, Philadelphia and one or two other cities. The names of the surgeons who have secretly been giving commissions or a portion of their fees will shock the profession if they are ever published. It is inconceivable how men who have posed leaders in every upward movement for the betterment of the profession could stoop to practices so reprehensible and stultifying.

Although strong pressure was brought to bear on us to print the evidence submitted, the specious argument being that publicity was the only effective way of overcoming the evil, we declined to lend our pages for the presentation of material that must necessarily prove so destructive to not a few reputations. Possibly some other publication may think otherwise and deem it proper to expose the evil-doers. Frankly, we feel that nothing is to be gained by serving evidence of scandal and wrong-doing to our readers, except, possibly, a little notoriety, and we do not aspire to further our journalistic progress by scandal-mongering. Such a course is contrary to our aims and policies, for it is essentially destructive—and nothing else. We believe there is a better way, a constructive course which consists of creating so strong a sentiment against the practice that no physician with an iota of self-respect will be

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a party to it in any way, shape or fashion. Once let it be thoroughly understood that fee-splitting or the giving or taking of commissions means professional ostracization, and no man who prizes his position *within* the profession will care to endanger it by a practice that will leave him so little self-respect.

American Medicine.

TINCTURE of iodine as an antiseptic and germicide in surgical technique is apparently becoming a permanent fixture if we are to judge by the increasing number of articles on the subject both here and abroad. Major Frank T. Woodbury of the Army Medical Corps has been a pioneer in this field, publishing several articles in the *New York Medical Journal* in 1910, and now, in the issue of February 11, 1911, he gives information of quite a number of other investigators and surgeons who have used it a long time. In some respects it seems to be ideal, and if the surplus is wiped or brushed off so that the surface is a dry brown, there are no symptoms of poisoning. It can be used even on the peritoneum, providing no excess drips down to collect in pockets. On account of the ease of use and the extreme simplicity, it is quite evident that this new method must be taken up to simplify our technique, which, ever since Lister's first suggestions, has been inordinately complicated and cumbersome. For the country practitioner nothing could be more desirable, and it may not be so very long when it will be safe to operate in farmhouses on cases now invariably sent to hospitals or allowed to go without relief. Indeed, the whole tendency of recent years has been to simplify methods which have really restricted surgical relief to a chosen few and rendered operations unconscionably expensive. We are great imitators, and many an operator who bundles himself up like a submarine diver may not be having any better results than he whose methods now look to be criminally simple because unorthodox.

American Medicine.

A NATIONAL SEWAGE COMMISSION is the last suggestion in the present discussion of the ways and means of reforming our present methods. Most of the problems to solve are local and each has its special difficulties not found elsewhere, so that every community must work out its own salvation in the future as in the past. Civilization also is becoming so complex that a central government cannot possibly attend to local details, but must confine itself to the larger problems of co-ordinating the works of localities, and represent them collectively in international relations. But it is in these purposes of a central government that we find the reasons why it must take up the matter of regulating sewage disposal. In the past, each community has solved the problem by simply dumping its filth on some neighbor—in accordance with the American idea of liberty to do as we please. The central government could not interfere and was forced to let

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the municipalities fight out their own troubles, but now it is found that the larger sewage schemes are crossing State lines and each State is complaining of being injured by its neighbors. Willy-nilly, the Federal Government must step in to define their respective rights and powers—but how can it do this without more knowledge of the matter? In addition to all this, it is now found that the harbors, which are all under the special control of the central powers, are being seriously injured by the enormous quantities of filth poured into them. The government must act, and very promptly too. It is one more reason for a Department of Health, with a subordinate Bureau of Sewage Disposal.

American Medicine.

THE wastefulness of present methods of sewage disposal is subsidiary to the main fault of injuring our beautiful water supplies and spreading disease. Nevertheless, in time it will become a vital matter to recover the vast quantities of nitrogen now thrown away. If a Sewage Bureau or Commission could solve this problem of the removal of nitrogen salts from sewage it would repay all expenses involved and a thousand times more. We mention this matter of dollars and cents for the benefit of those sordid souls who look upon all such problems from the financial side and who care little for the saving of health and prolongation of life sure to result when we stop our disgusting habit of emptying our closets in our neighbors' yards. But think of the folly of deliberately ruining our crystal lakes and rivers! We have destroyed water supplies worth untold billions and are now spending hundreds, yes thousands, of millions to get fairly decent drinking water to the dense masses of our cities. There is absolutely no reason why any community should be permitted to use any natural water course as a sewer, and the time is near at hand when it must be stopped, as we need the water.

American Medicine.

THE problems of sewage disposal are thus seen to be so numerous and vital that they must be attacked in earnest—not only by local communities, such as villages, towns and cities, but by the States and the United States. Commissions must be created, experimental stations organized, expert specialists trained and new methods devised as quickly as possible. Through these means it will soon be possible for every community to dispose of its own wastes and pass on to its neighbors nothing but water clean enough to drink. This seems utopian now, and so it is, but it is an utopia which can be reached in time and we must reach it if we are to obey the modern law of cleanliness. So by all means let us have a National Sewage Commission at once. When the Department of Health is organized, the commission will automatically become one of its bureaus and no time will be lost in waiting. We commend the present movement, for we have formally taken the firm position that the Federal Government must control the matter of sanitary sewage disposal near harbors and interstate waterways, whether navigation is injured or not. It is health we advocate, not commerce, though both are essential.



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NATIONAL MEDICAL MEETINGS, 1911

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	Atlantic City, June, 1912
" Acad. of Ophthalm. and Oto-Laryngology.....	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.....	
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	
" Army and Navy Medical Association.....	E. P. Bartlett, Springfield, Ill.....	
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	
" Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York.....	
" Assn. of Military Surgeons of the U. S.....	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston.....	
" Assn. of Railway Surgeons.....	Louis J. Mitchell, 67 Wabash Ave., Chicago.....	
" Medical Temperance Association.....	T. D. Crothers, M.D., Hartford, Conn.....	
" Assn. for the Stu. of the Feeble-Minded.....	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo.....	
" Assn. of Official Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.....	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.....	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	June, 1912
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York.....	St. Louis, June, 1912
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave., Detroit, Mich.....	Baltimore, May, 1912
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York.....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago.....	Atlantic City, June, 1912
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	May 28-31, '12
" Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington, D. C.....	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston.....	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.....	Hot Springs, Va., May 29-31, '12
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.....	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C.....	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
" Public Health Association.....	William C. Woodward, Washington, D. C.....	
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass.....	
" Surgical Association.....	Robt. G. Le Conte, 1530 Locust St., Philadelphia.....	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
Assn. Med. Officers A. and N. of Confederacy.....	A. A. Lyon, M.D., Nashville, Tenn.....	
Balto. & Ohio Assn. of Railway Surgeons.....	T. A. Murphy B. & O. Bldg., Baltimore, Md.....	
British Medical Association.....	Guy Ellison, London, England.....	
Canadian Medical Association.....	George Elliott, M.D., Toronto, Canada.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.....	Rome, 1911
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky.....	
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	Colfax, Ia., March 21-22, '12
Nat. Con. State Med. Exam. and Lic. Boards.....	A. W. Suiter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis.....	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto., Md.....	May, 1912
Pan-American Congress, Fifth.....	Dr. Ramon Gutierrez.....	
Seaboard Medical Assn. of Va. and N. C.....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.....	W. D. Haggard, Nashville Tenn.....	
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	
Tri-Medical Soc. of Md., W. Va. and W. Pa.....	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.....	R. McKinnery, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo.....	
Western Surgical and Gynecological Assn.....	A. T. Mann, M.D., Minneapolis Minn.....	

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

A Distinctive Piece of Literature.

"HERE is something different." This is apt to be the first thought of the physician upon breaking the wrapper of Parke, Davis & Co.'s new brochure on bacterial vaccines and tuberculins. And the external appearance of the book is in no wise misleading. The "difference" applies to the printed page as well as to the handsome cover in artistically-blended browns and gold. The brochure contains 48 pages, in addition to the cover, and 13 full-page engravings in colors.

The work is divided into three parts or sections. Some of the subjects considered in the first section are: "What Is the Difference Between Bacterial Vaccines (Bacterins), Serums and Toxins?" "How Are Bacterial Vaccines Prepared?" "Therapeutic Action of Bacterial Vaccines." "When Should Serums Be Used, and When Bacterial Vaccines?" The second section treats of the origin and nature of the bacterins, the relative merits of "stock" and "autogenous" vaccines, the opsonic index and the best method of using the bacterins, together with a description of each vaccine, including references to preparation, therapeutics and dose. The third section is devoted to a consideration of the tuberculins, with dilution and dose tables, descriptions and illustrations of the various diagnostic tests, etc.

Briefly stated, the booklet is a concise review of the essential facts relating to bacterial-vac-

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Abdominal Support in Pregnancy.

THE wisdom of supporting the abdomen during the late stages of pregnancy and occasionally from the very beginning is becoming more generally recognized. The advantages have been conclusively demonstrated, not alone by assuring greater comfort, but quite as substantially by the prevention of many of the disagreeable and more or less serious complications of pregnancy traceable to abdominal sagging. The large amount of thought that has been given to the proposition is shown by the development of special forms of support. Unquestionably any measure or appliance approaching closest to every-day customs and requiring the least possible change in a patient's

usual manner of dress deserves special consideration. To the painstaking medical man the Storm Binder is bound to present a special appeal. Careful scientific study of the anatomical requirements are reflected in this splendid maternity supporter, and the physician is bound to commend the effective support afforded without forcing a woman to wear an unnatural and unpleasant apparatus.

The Storm Abdominal Binder solves a most important problem, and the benefits obtained from its use show how perfectly adapted it is to the necessarily exacting needs of the pregnant female. The comfort that attends its use is a feature second only to the complete support it constantly gives. Limited space prevents elaboration of the many important and interesting facts connected with the Storm Binder, and every physician who is interested in promoting the welfare of his pregnant patients should turn to page 4 and send forthwith for full description.—*American Medicine.*

The Appetite in Tuberculosis.

IN view of the fact that hypernutrition, or so-called forced feeding, constitutes one of the important indications in the treatment of many

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cases of tuberculosis, more than ordinary attention must always be devoted to maintaining the appetite. Unfortunately, many of these patients have an aversion to the very foods which are best adapted for repairing and resisting the ravages of the disease. It is here that Gray's Glycerine Tonic Comp. serves one of its most important purposes, by reason of its notable capacity to awaken a deficient appetite in a perfectly natural manner. It not only possesses the desirable feature of great palatability, but through its tonic properties it never fails to impart just the right tone to the digestive organs. Thus the effects are so much more permanent and far-reaching than are obtained from ordinary stomachics, that not only are larger quantities of nourishment freely taken by the patient, but a correspondingly increased amount finds its way to the remote tissues.

Again Urotropin in Meningeal Infections.

AMONG the recent contributors to the subject of the use of Urotropin as an important prophylactic and therapeutic measure in meningeal infections are:

Dr. M. Allen Starr, Professor of Neurology, College of Physicians and Surgeons, Columbia University, New York, in an article, "The Prevention of Epidemics of Infantile Paralysis" (*Medical Record*, August 5, 1911).

Dr. C. Eugene Riggs, Professor of Nervous and Mental Diseases, College of Medicine and Surgery, University of Minnesota, and Dr. E. M. Hammes, St. Paul, in a communication, "Acute Meningeal Infection: A Case for Diagnosis" (*St. Paul Medical Journal*, November, 1911).

Drs. Simon Flexner and Paul F. Clark of the Rockefeller Institute, New York, in a paper, "Concerning the Control of Epidemic Poliomyelitis," read before the Twenty-sixth Meeting of the Association of American Physicians at Atlantic City, May 9-10, 1911 (*Boston Medical and Surgical Journal*, June 22, 1911). During the discussion following this paper, Dr. Flexner emphasized that Urotropin should be given at the earliest possible moment.

Dr. R. Tunstall Taylor, Professor of Orthopedic Surgery, University of Maryland, in an

article on "Our Present Knowledge in Regard to Infantile Paralysis" (*American Journal of Surgery*, November, 1911).

Dr. Robert Earl, Surgeon of the Bethesda Hospital and Mounds Park Sanitarium, St. Paul, writing on "Technique in Brain Surgery" (*St. Paul Medical Journal*, November, 1911), calls attention to the often-emphasized importance of administering Urotropin as a prophylactic before operations on the brain.

Hope for the Tuberculous Patient.

WHEN demonstrable lesions of tuberculosis show the steady progress being made by the infection, the physician owes it to his patient as well as to himself to put at the unfortunate one's command whatever advantages may be open to him. Right living, sleeping in the open and the choice of a proper dietary, coupled with such drug therapy as may be indicated, offer the most hope to the tubercular patient who is not in position to seek another climate and lung specialists. The indications for drugs are met by Cord. Ext. Ol. Morrhuae Comp. (Hagee), for in it are properties well calculated to soothe the irritated mucosae, make the cough more bearable and maintain strength and resistance of the hard-pressed tissues. Cord. Ext. Ol. Morrhuae Comp. (Hagee) possesses the added advantage of not disturbing nutritional processes, as do so many agents of its class, rendering them a hindrance instead of an aid.

Ethyl Alcohol from Wood Waste.

ANNOUNCEMENT is made by the Wood Waste Distilleries Company, Wheeling, W. Va., U. S. A., of a new process for the manufacture of the highest grade of ethyl alcohol from sawdust, the triumph of which has been achieved after six years of incessant labor and experiments by Carl von Hartzfelt and son.

A big plant has already been installed by the United Industrial Alcohol Company, 105th street and New York Central Railroad, at Cleveland, O., converting sawdust into ethyl alcohol, which analysis shows to be of higher calorific value and of greater purity than grain alcohol. It will enter the field not only as a lower-priced competitor of the grain alcohol, but it will, according to those who have studied the situation, become a powerful competitor of gasoline and kerosene. Aside from these important features, millions of bushels of corn now used for grain alcohol will be released for food purposes.

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and other respiratory affections so often owe their intractability to malnutrition and debility that vigorous tonic medication always forms one of the first and most important indications for their treatment. The results that uniformly follow the use of

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in this class of affections, prove the wisdom, therefore, of "treating the patient as well as the disease." The exceptional efficiency of this time-tried tonic in all diseases of the air passages has led to its widespread recognition as one of the general practitioner's most dependable allies in his annual conflict with winter coughs and colds.

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BALTIMORE

Medical Items.

DR. FLORA POLLACK has removed her office from the Professional Building to 1112 North Eutaw street, between Hoffman and Dolphin streets, Baltimore.

DR. EMIL NOVAK was operated on recently at the Mercy Hospital for appendicitis. Dr. A. C. Harrison performed the operation. Dr. Novak is reported to be recovering rapidly.

DR. JOHN H. HOGAN of the house staff of Mercy Hospital will succeed Dr. William W. Hobson, resigned, as chief of the accident department of the hospital.

THE Public Health Conference, held in Baltimore February 19 to 24, was largely attended and highly successful.

THE engagement is announced of Miss Florence Brush, daughter of Dr. Edward N. Brush of Towson, to Dr. George W. Shippen of Baltimore. Dr. Shippen is a graduate of the Johns Hopkins Medical School.

DR. AND MRS. SYDENHAM RUSH CLARKE are receiving congratulations upon the birth of a son—Addison Clarke—February 5, 1912.

DR. MARCUS L. DILLON, superintendent of Franklin Square Hospital, is very ill in that hospital with septicemia, following an operation wound.

DR. ABRAHAM SAMUELS is spending three months in the Adirondacks.

DR. HENRY CHANDLEE is spending February in Bermuda.

A NEW hospital was opened in South Baltimore February 19. It has 25 beds, and is in charge of Drs. Clarence P. Erkenbrach, William D. Olmstead and Edward J. Miller.

DR. AND MRS. CLEMENT A. PENROSE are receiving congratulations upon the birth of a son.

MARRIAGES.

GUSTAV H. WOLTERECK, M.D., of Baltimore, to Miss Helen Edith Black of Ridley Park, Pa., at Ridley Park, February 14, 1912.

ARTHUR EDWARD EWENS, M.D., University of Maryland, '04, to Miss Florence Lane Johnson, both of Atlantic City, at Atlantic City, N. J., February 27, 1912.

DEATHS.

LOUIS W. MORRIS, M.D., University of Maryland, '85, at his home in Salisbury, Md., February 2, 1912, aged 46 years.

JOHN FLETCHER POWELL, M.D., University of Maryland, '53, at his home in Baltimore, from the infirmities of old age, aged 81 years.

THOMAS COAN, M.D., Johns Hopkins Medical School, at his home in New York, of pneumonia, February 4, 1912, aged 26 years.

WILLIAM H. ARCHIBALD, M.D., Baltimore Medical College, '95, at his home in Jeffersonville, N. Y., January 3, 1912, of heart disease, aged 45 years.

AMOS BURR STRAIGHT, M.D., College of Physicians and Surgeons, '91, at his home in Hornell, N. Y., January 9, 1912, of heart disease, aged 45 years.

ENOCH GEORGE, M.D., University of Maryland, '72, at his home in Denton, Md., January 12, 1912, of pneumonia, aged 62 years.

MATTHIAS ADOLPH E. BORCK, M.D., University of Maryland, '63, at his home in St. Louis, Mo., January 20, 1912, from senile debility, aged 77 years.

NATHAN D. TOBEY, M.D., University of Maryland, '63, at his home in Vaughn, N. M., January 19, 1912, aged 74 years.

JAMES F. BECKWITH, M.D., College of Physicians and Surgeons, '81, at Mercy Hospital, Wilkes-Barre, Pa., January 23, 1912, from embolism, aged 59 years.

JACOB E. POWELL, M.D., College of Physicians and Surgeons, '90, at his home in Findlay, Ohio, January 19, 1912, from pneumonia, aged 50 years.

NORTON ROYCE HOTCHKISS, M.D., University of Maryland, '91, at his home in New Haven, Conn., January 30, 1912, of leukemia, aged 41 years.

PETER H. LATHAM, M.D., University of Maryland, '76, at his home in Weatherby, Pa., January 23, 1912, of diabetes, aged 62 years.

ARTHUR M. WALKUP, M.D., College of Physicians and Surgeons, '81, at his home in Gala, Va., January 31, 1912, of cerebral hemorrhage.

ANTHONY J. MOORE, M.D., Maryland Medical College, '00, of Philadelphia, in St. Joseph's Hospital, Philadelphia, February 5, 1912, of pneumonia, aged 35 years.

Looking Into The "Coffee Question"

necessarily involves a consideration of the now well-known and well-established cereal beverage



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With modern advances in pharmacy—the discovery and isolation of alkaloids and a knowledge of their physiological action on the human system—has come a more intimate knowledge of the

Uses and Abuses of Caffeine

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As in some other instances, people have learned that **something** in Coffee causes various ailments. It remained for science to discover and define that "something." It is now known to be **Caffeine**.

But to induce mankind to forego Coffee, even though it contains a drug, was no easy task for the physician or nurse.

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The "Clinical Record" for the physician's bedside use will be sent, prepaid, to any physician or nurse who has not already received one. Also a box of samples of Postum, Grape-Nuts and Post Toasties.

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Editorial Comment.

DANGER IN ANESTHESIA.

The Medical Brief.

EVERY little while we are treated, in various quarters, to disquisitions of various length and fervor upon the dangers attending the administration of anesthetics. We are told that chloroform is a highly dangerous agent; that ether is not much better; and even the old ACE mixture of the English anesthetist, which used to be regarded as so safe and adequate, has of late been discarded as undesirable and risky. It seems, in fact, that every day's experience and observation adds some new element of danger and undesirability to the various anesthetics and their combinations, until they teem with risks which were never suspected in former times.

Now it is quite right and proper, of course, that the dangers which lurk in anesthesia should be keenly scented out and frankly exposed. It is a good sign of the times. It shows that the subject is receiving careful study, and that the surgical profession is alive to the necessity for conserving the life and health of their unfortunate patients who are obliged to undergo the ordeal of the surgeon's knife. And there is no doubt that the greater part of the charges that are brought against both chloroform and ether from time to time are warranted by the facts. There are unquestionably many untoward results from their administration, other than the death of the patient on the table, which in the earlier days of anesthetics we did not suspect. And it is altogether a thing to congratulate ourselves upon, that we no longer administer these agents with the airy nonchalance that characterized our former attitude toward anesthesia.

Yet the fact remains that anesthesia has come to stay, and can not be reasoned out of necessity and general usage by arguments about its dangers, direct or remote. We simply can not do without it; and, indeed, its advantages and benefits, viewing it from the most pessimistic standpoint, have been so overwhelmingly in excess of its evils that nobody dreams of attempting to do without it. Moreover, so far as we are able to see, there does not thus far seem to be any serious prospect of supplanting chloroform and ether as the staple agents of anesthesia. With all their faults, which, as we have said, seem to multiply with the days, nobody has as yet had anything to offer which can take their place. Spinal anesthesia, from which so much was promised a few years ago, somehow or other does not seem to make good. And the other general anesthetics only serve as occasional substitutes in exceptional instances.

It seems likely, therefore, that we are destined to use these two agents in our anesthesia work for some time to come, and it would appear to be the part of wisdom to make the best of them. This being the case, it is a little strange that the only feature of the matter in which we can really accomplish a great deal towards insuring safety and comfort in anesthesia is almost entirely neglected in American hospitals, namely, the personnel and training of the anesthetist. In spite of the growing appreciation of the importance and danger of this part of the surgical operation, the task of administering the anesthetic is still, in practically all the

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hospitals of this country, delegated to a comparatively inexperienced interne, who performs it for a few months at the outside, and then hands it over to his equally green successor.

In England and Europe there is scarcely a hospital of any importance that does not have its professional expert anesthetist, just as it has its staff surgeons and physicians—a man of age and skill and experience equal to that of the operating surgeon. The writer asked one of these experts on one occasion what, in his opinion, was the safest anesthetic. He replied that almost every anesthetist had his own preference, and that his was pure chloroform unless it was positively contraindicated, “but,” he added, significantly, “I want to give it.” There, in our judgment, is the crux of the whole situation—and there is the point which American writers and practitioners almost uniformly ignore. The current anesthetics, as we have said, have come to stay, at least for a time. It is beside the mark to dilate upon the inherent dangers of the drugs themselves. Their ultimate safety or danger lies in the personnel and training of the men who administer them; and their administration demands as great a degree of expertness as the surgery to which they are handmaids.

REPORTING VENEREAL DISEASES.

WHY, we ask for the hundred thousandth time (we do not mean, of course, that we have personally put the question that number of times, but it is a moderate estimate of the frequency with which it has been raised in the minds and by the lips of physicians and hygienists), why do the State and municipal laws which very properly require the reporting of communicable diseases, weakly make an exception in the case of that commonest and worst type of communicable disorders, the venereal diseases? Why is the attending physician required to report a case of typhoid fever, or tuberculosis, or whooping cough—we mention those in which, under modern conditions, the chances of communication are reduced to a minimum by intelligent restriction and regulation—and utterly exempted from reporting a case of gonorrhea or syphilis, around which there are absolutely no safeguards thrown by either State or individual, and in which communication to some innocent party is almost inevitable?

We know the answer, of course. An ancient, bewhiskered answer. The sensibilities of the persons who contract venereal diseases; the fear that, if they knew themselves to be subject to report, they would conceal their condition, refuse to consult a physician for their cure, and thus become an even worse focus of contagion than under present lack of regulation: consideration for the moral (or immoral) element that plays such a part in the matter; these are, as they have always been, the stock arguments against compulsory reporting of venereal diseases.

They are, in our opinion, specious reasons every one, and will not hold water. They are, indeed, nothing but an extension of the very same objections which were formerly urged against the reporting of tuberculosis, but were beaten down by considerations of public policy. There is no good reason, in these days, why the sensibilities of the individual should prevail against the public health and safety. Tuberculous patients are sensitive, too. For many reasons—some of them much more solid than mere personal

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Mellin's Food contains maltose derived from wheat and barley in a natural way, not by the acid process, but by the action of the enzymes of sound barley malt upon prime, full wheat. The maximum amount of digestible proteins is also retained, resulting in the all-important food-sugar and proteins so necessary to furnish a well-balanced ration for the growing infant.

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squeamishness—why a person suffering from tuberculosis does not care to have it made public knowledge. But we recognize, and he recognizes, too, if he be a sensible man, that such considerations are outweighed by those of public weal, in which he and his are just as much interested as the rest of mankind. The same is true of gonorrhea and syphilis. And if it be objected that in these diseases there is an element of shame which does not pertain to tuberculosis—why, then we ask, in surprise, whether these same considerations of public health and safety, which override all other personal consideration, are to humbly respect and softly spare the blushes of a man who has done something he is ashamed of?

But the women and children who suffer innocently from venereal complaints. Shall we pillory them, too? We know that old argument also, and are too old birds to be caught by any such palpable chaff. If these victims of venereal disease are innocent, then, to be sure, no shame can attach to their sufferings, so that part of the argument falls to the ground, at least so far as they are personally concerned. And so far as the reflected disgrace is concerned—we would like to enquire whether the vote of the women and children was ever taken on the subject. Is it not, as a matter of fact, the men who urge this sentiment—hiding themselves behind the women's skirts?

As to such a regulation keeping the victims of venereal infection away from the physician, we take no stock in that objection. The man who contracts a venereal disease is not, as a rule, especially shy of having his condition known to anyone except to the very persons to whom he ought to make it known. On the contrary, compulsory reporting of the venereal diseases would put an end to a lot of the clandestine treatment by druggists and quacks which now prevails; and, what is better still, it would insure those victims receiving proper care who now, unfortunately, do not get it—the innocent women and children of whose sensibilities we are so tenderly considerate!

We fear that the real arguments against it are the men themselves. And since men make the laws, it is hardly likely that it will become popular. Perhaps some day the women will take a hand, and then we shall see. Suffragettes, please take notice.

DOSES AND METHOD OF ADMINISTRATION OF DIPHTHERIA AND TETANUS ANTITOXIN.

The Medical Record.

DR GEORGE W. GOLER, Health Officer of the City of Rochester has issued the following card of instructions to the physicians of that city. As a crystallized statement of the dosage and method of administration of antitoxin, the very practical instructions are worthy of wide distribution.

Dr. Wm. H. Park of the Research Laboratory of the New York City Health Department, has proven by animal and human inoculation that it takes some time for the antitoxin to be absorbed from the subcutaneous tissue. Specimens of blood withdrawn from treated cases show maximum amount is not absorbed until 24 to 48 hours. That, when one administers diphtheria antitoxin in repeated doses, say 5000 units repeated ever 12 hours for three doses, the maximum antitoxin content of the blood is never

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¶ Do you know that a cent's worth of Solidified Alcohol will keep a six-pound flat-iron hot for fifty-five minutes; will make four cups of coffee; will keep an eight-inch disc stove hot for seven minutes, or long enough to cook a steak; will bring to boil two quarts of water, or operate the baby milk-warmer twice; will make a Welsh rarebit in a chafing dish; will operate a seven-inch frying-pan twelve minutes; will keep a heating pad hot two hours; will operate a griddle eight minutes; will keep a foot-warmer hot thirty minutes; will run a boiler nine minutes; will vulcanize a patch on an automobile tire?

¶ The secret of the production of this industrial alcohol in chunks is very simple and cheap. You can have it for a very small consideration. Can be made cheaply at home and sold in drug stores with good profits. A sample can containing twenty-six solid alcohol cubes, with a stove for burning same, will be sent to any address, postpaid, on receipt of **\$2.00**.

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so high, nor is this maximum content reached anywhere near so quickly as it would be if, say 15,000 units had been given as an initial dose. Further, the antitoxin is absorbed more rapidly when it is injected intramuscularly than subcutaneously, and of course, it is all immediately absorbed if injected intravenously. In view of these facts we recommend that the initial dose should be large. In fact, if one sees a case in which one is more or less decided that one will give, say 15,000 units in three or four doses, that one should give this all in one dose. Approximately, these would be the doses recommended for cases seen early:

One tonsil involved, constitutional symptoms not marked, not less than 3000.

Both tonsils involved, constitutional symptoms fairly severe, not less than 6000.

One or both tonsils involved, constitutional symptoms severe, not less than 9000.

Nasal or laryngeal diphtheria and all in which constitutional symptoms are severe, not less than 12,000.

When the cases are seen late in the disease, and are not already improving it is recommended that *these doses should be doubled* or given intravenously, or both.

For very severe cases with extensive membrane and marked constitutional symptoms, 20,000 units given intravenously.

Dr. Park reported that in their cases the advantage of giving antitoxin intravenously in laryngeal cases has not been so marked as in the cases with pronounced toxæmia. (However, it might be that in a more extensive series of cases this method would show better results.

For immunizing use a 1000 unit for all ages.

Tetanus. In cases of developed tetanus, a large dose (20,000 units) should be given intravenously at the earliest possible moment, and in about 12 hours a second dose should be given subcutaneously.

CHRISTIAN SCIENCE IN THE CANAL ZONE.

The Medical Record.

IN the issue of the *Medical Record* of January 27 attention is called by a correspondent to the startling fact that the Christian Science healer has received a special dispensation from the Canal Zone administration to practice his sanctimonious calling. Dr. Baruch had commented on the singular fact that in the Zone, where the United States Government has achieved the greatest sanitary triumph of modern times solely through the efforts and sacrifice of medical men, it discriminates against the latter by placing the science healer on an equality with the physician who has expended years of study and effort to master his profession, and from whom it demands an examination and license. The Secretary of War made an absurd defense of his anomalous position, and now comes an anonymous, probably inspired, writer in the *Sun* of January 27, who claims that, in addition to the States (Connecticut, Maine, New Hampshire, South Dakota, and Tennessee) enumerated by our correspondent as exempting these healers from the license required by medical men, there are Illinois, Kansas, Louisiana, Utah, Massachusetts, and probably Vermont

INDEX

TO

Medical Advertisements

PAGE II

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The majority of physicians are of the opinion that **UNG. RESINOL** yields better results than any other ointment used in overcoming eczema, because—

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UNG. RESINOL cleans up the surface while internal medication is building up the general system.

When the eczematous area is covered with crusts they should be removed with warm water and Resinol Soap. Then **UNG. RESINOL** should be applied on a piece of linen or muslin, covered by an ordinary bandage. The dressing should be renewed every six to twelve hours, according to the severity of the itching.

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The physician, whose face is made tender by constant exposure, will find this soap unexcelled for shaving. It gives a creamy lather, is antiseptic, prevents infection and is insurance against skin troubles.

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BALTIMORE, MD.

and Washington which have legislation similar in purpose. It is surely admitted, he writes, "that this is an imposing array." Not at all.

We have taken pains to investigate this addition which is claimed to form the "imposing array," with the following result: Massachusetts does exempt from license and examination "registered pharmacists prescribing gratuitously, osteopaths, clairvoyants or persons practising hypnotism, magnetic healing, mind cure, massage, Christian Science, or cosmopathic method of healing," provided, however, they do not violate the provisions of Section 8, which reads: "Whoever not being lawfully authorized to practice medicine holds himself out as a practitioner of medicine . . . shall for each offence be punished," etc. Illinois provides that "the examination of those who desire to practice any other system or science of treating human ailments, who do not use medicines internally or externally, shall be of a character sufficiently strict to test their qualification as practitioners." In Vermont, after providing that all practitioners of medicine shall be examined and licensed, the law says: "The provisions of this act shall apply to persons professing or attempting to cure disease by means of faith-cure, mind-healing, or laying on of hands, but shall not apply to persons who merely practice the tenets of their church." In Utah, after providing that all practitioners be examined and licensed, the law says: "This act does not apply to those who heal only by spiritual means without pretending to have knowledge of the science of medicine." In Louisiana, after carefully providing that all practitioners are examined and licensed, the law says: "Nothing in this act shall be construed to prohibit the practice of religious tenets of any church whatsoever." In Kansas all physicians must be licensed as in other States, but "the act does not apply to domestic medicine or gratuitous service." In the State of Washington all persons practising medicine must be licensed and no exception is made for any reason whatever. It has remained, therefore, for the Canal Zone administration, not to "follow the legislation of a large and important number of States" (the imposing array numbers seven), but actually to lead them all by permitting the practice of the religious tenets of any church in the ministration to the sick or suffering by mental or spiritual means, whether gratuitously or for compensation. This clause is found in the laws of no other State in the Union. Of what use is it for any one to spend years in preparation for the study of medicine, then pass six years in study and hospital work, if one may adopt the more simple and direct way to become a healer, practise medicine without let or hindrance, and escape State examination?

Dr. Baruch's suggestion that the medical profession take immediate and effective action to meet these disgraceful encroachments on its rights and privileges is worthy of serious consideration. It would seem on calm consideration of all the data that medical men are actually legislated against by several States in order to protect the special interests of clairvoyants, magnetic healers, Christian Science healers, *et id genus omne*. The situation demands investigation by competent legal authority to determine whether our rights as citizens are not discriminated against by the laws of these seven States, and whether there should not be a resort to legal steps to secure these rights.

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Many cases of throat trouble have been traced to the telephone. Many transmitters are noticeably dirty and mal-odorous.

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G. M. Linthicum, L. F. Barker,
W. R. Eareckson, Hiram Woods,
D. Streett, H. B. Grant,
A. H. Hawkins.

Delegates to American Medical Association

1909-1910.

L. F. Barker. *Alternate*—S. T. Earle.

1910-1911.

R. B. Warfield. *Alternate*—R. Winslow.**Committee on Scientific Work and Arrangements**

J. A. Chatard, A. M. Shipley, J. Holmes Smith, Jr.

Committee on Midwifery

G. Dobbin, M. Sherwood,
J. K. B. E. Seegar, C. R. Foutz,
H. M. Fitzhugh, C. A. Clapp.

Library Committee

J. W. Williams, C. B. Gamble, H. B. Jacobs,
R. B. Warfield, Gordon Wilson.

Memoir Committee

A. C. Pole, F. Kirby, J. C. Pound,
L. W. Morris, B. J. Byrne.

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E. F. Cordell, Theodore Cook, Sr., W. M. Lewis,
J. F. H. Gorsuch, O. H. Ragan.

Committee on Public Instruction

H. G. Beck, C. N. Branin, S. McCherry,
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Committee on Medical Education

W. H. Howell, David Streett, C. F. Bevan,
R. Winslow, W. S. Smith.

Committee on Sanitary and Moral Prophylaxis

D. R. Hooker, C. N. Athey, Lillian Welsh,
O. E. Janney, Andrew Whitridge.

Committee on Tuberculosis

J. Girdwood, G. W. Mitchell, R. Urquhart,
V. Cullen, W. H. Pearce.

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REGULAR MEETINGS OF THE BOARD OF MEDICAL EXAMINERS OF MARYLAND.

Fourth Tuesday in April.

First Tuesday in June.

First Wednesday in October.

First Wednesday in December.

REGULAR EXAMINATIONS.

Examinations are held in Baltimore—

Third Tuesday in June for four consecutive days.

Second Tuesday in December for four consecutive days.

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Information connected with medical examinations and licensure by addressing Secretary J. McP. Scott, Hagerstown, Md.

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NATIONAL MEDICAL MEETINGS, 1911

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa....	Atlantic City, June, 1912
" Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	
" Army and Navy Medical Association...	E. P. Bartlett Springfield, Ill.....	
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York...	
" Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York..	
" Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston...	
" Assn. of Railway Surgeons.....	Louis J. Mitchell, 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
" Medical Temperance Association.....	T. D. Crothers, M.D., Hartford, Conn.....	
" Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo....	
" Assn. of Official Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	June, 1912
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York...	St. Louis, June, 1912
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	Baltimore, May, 1912
" Larynx, Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 49th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York...	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago...	Atlantic City, June, 1912
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	May 28-31, '12
" Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill...	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia...	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	Hot Springs, Va., May 29-31, '12
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C...	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
" Public Health Association.....	William C. Woodward, Washington, D. C.....	
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass.	
" Surgical Association.....	Robt. G. Le Conte, 1536 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
Assn. Med. Officers A. and N. of Confederacy	A. A. Lyon, M.D., Nashville, Tenn.....	
Balto. & Ohio Assn. of Railway Surgeons...	T. A. Murphy B. & O. Bldg., Baltimore, Md...	
British Medical Association.....	Guy Ellison, London, England.....	
Canadian Medical Association.....	George Elliott, M.D., Toronto, Canada.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	
International Congress on Tuberculosis...	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	Rome, 1911
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky...	
Missouri Valley Medical Society of the...	Chas. Wood Fassett, St. Joseph, Mo.....	Colfax, Ia., March 21-22, 12
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Suiter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis...	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	May, 1912
Pan-American Congress, Fifth.....	Dr. Ramon Gutieras.....	
Seaboard Medical Assn. of Va. and N. C...	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville Tenn.....	
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo...	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn...	A. T. Mann, M.D. Minneapolis Minn.....	

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sandner & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sandner & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

A Pleasant, Efficient Laxative.

THE desirable qualities of a first-class laxative are efficiency and freedom from unpleasant taste. The lack of either to just that extent disqualifies the product for use in the treatment of chronic constipation. That it is difficult to find a palatable and efficient laxative in the same medicament is a pretty generally accepted fact. It is possible to do so, however, and Cascara Evacuant may be cited as proof of that possibility. This preparation is pleasant in taste, and in doses of 15 to 30 minims in water it performs its duty quickly and well, without incidental nausea or distress. That is why children rarely object to taking it, and adults prefer it to other preparations.

The product is manufactured by Parke, Davis & Co. and is procurable from any well-stocked retail pharmacy. To avoid confusion with other so-called aromatic cascara, however, it is well to specify clearly "Cascara Evacuant, P. D. & Co."

Fuel for the Body.

ONE of the best means of supplying the body with fuel is cod liver oil, for in it are the elements needed by the tissues to take the place of those lost in the phenomenon of energy-production. This is the reason that cod liver oil is widely resorted to for the purpose of restoring strength and energy to an organism, reduced

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MAKES PLAINER THE RAISON D'ETRE OF
CERTAIN CLINICAL FACTS. THUS, A KNOWLEDGE OF THE CHEMI-
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in vigor as a consequence of a protracted illness. In the selection of a special preparation of the oil the two determining factors should be: First, efficiency; second, palatability, and since these two requirements are clearly met by Cord. Ext. Ol. Morrhuæ Comp. (Hagee), it is, in a vast majority of cases, the agent of choice. Cord. Ext. Ol. Morrhuæ Comp. (Hagee) contains in pleasant form the active principles of the oil, reinforced by the hypophosphites of soda and calcium, and may be ordered with every confidence in its power to charge the tissues with needed fuel.

The Treatment of Convulsions in Infants.

By Harry Tyldesley, M.D.

ONE of the most frequent morbid conditions encountered in the treatment of the diseases of child life is convulsions.

The treatment of convulsions very naturally resolves itself into two indications—the removal of the cause and the institution of those measures—which relieve the congestion of the brain.

A study of the case in hand will reveal the causative influences and suggest those remedies that are indicated to remove the cause. Where

the stomach is full of indigestible foods it must be emptied, and in a like manner other remedial measures must be addressed to the removal of the cause.

It is highly important that the physician go to work with the most earnest efforts to relieve the convulsive seizure. The inhalation of chloroform is useful in some cases. It should be given until there is no convulsive movement. I put all infants as soon as I see them in a bath of warm water and give them a dose of Neurosine. This agent speedily overcomes the congestion of the brain and the child falls into a peaceful sleep, from which it usually awakens with a clear head and no tendency to convulsions. Besides this, Neurosine contains no opium, chloral or morphine, and it is, therefore, admirably suited to these cases.

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In the practices of thousands of physicians Pasadyne has supplanted all other drugs in producing sleep on account of its demonstrated superiority. The sleep it brings about is calm and restful; the patient awakens as refreshed as from natural sleep. A sample bottle will be furnished if application be made to the Laboratory of John B. Daniel, Atlanta.

Chronic Nasal Catarrh.

By Geo. A. Hewitt, M.D., Philadelphia, Pa.

CASE I. —, a man, 34 years of age, had suffered for years, especially in cold or damp weather, from difficulty of breathing, accompanied by a thin discharge from the nose. At night he was obliged to sleep with his mouth open. He was prone to attacks of follicular tonsillitis. This man was appreciably benefited by a course of arsenic internally and the persistent local use of Glyco-Thymoline. In the course of a few weeks the situation was entirely changed. A sense of obstruction was then seldom present. The discharge had disappeared. He is now almost free from his old symptoms. Whenever there is any threatened recurrence, he has immediate recourse to his bottle of Glyco-Thymoline.

CASE II. —, a woman, aged 22 years, had suffered for years from an aggravated case of hypertrophic rhinitis. Obstruction was marked; discharge was constant. At night she constantly breathed through her mouth. She was

subject to sore throats and attacks of bronchitis. This patient was directed to take hypophosphites, malt and cod-liver oil, as she was of a distinctively strumous diathesis. Withal, however, she was possessed of considerable muscular strength, and, aided by the local action of Glyco-Thymoline, made a very satisfactory recovery.

OUR readers will note in this issue for the first time the artistic advertisement of Palpebrine, the safe and reliable remedial agent in all external inflammation of the eyes. This product is manufactured by the Dios Chemical Co., who have, during the last quarter of a century, manufactured exclusively for physicians Dioiburnia, Neurosine and Germileum, the reliability of which is generally recognized.

No new and untried drugs enter into the composition of these specialties and their formulae have always been communicated to the profession. Palpebrine will fill a long-felt want of the general practitioners, who can themselves treat with this product, safely and successfully, external inflammation of the eyes.

The Dios Chemical Co. of St. Louis will mail free trial bottle of Palpebrine on application.

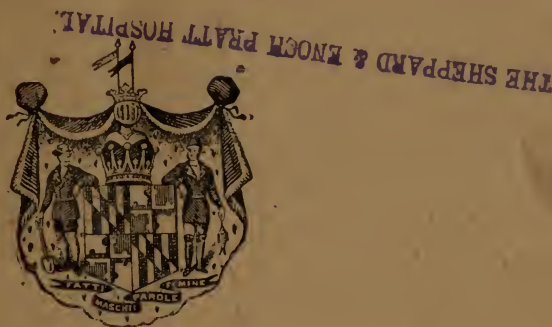
"For some years there has been a tendency among the profession to use sodium salicylate to the practical exclusion of other agents in the treatment of acute articular rheumatism. Even the therapeutic nihilist has conceded to sodium salicylate the first place in rheumatism, as he accords it to quinine in malaria, or to antitoxin in diphtheria.

"The recent reports by Menzer, a surgeon in the German army, tend to discredit the too implicit faith placed in the use of the salicylates alone in acute articular rheumatism. It is not denied that the salicylates pushed to effect will alleviate the symptoms, but he asserts that cases so treated are more subject to relapse and to permanent deformity than are those in which other remedies are exhibited, and that there should be incorporated with the salicylates other agents which will not encourage injurious complications."

In Tongaline sodium salicylate from the natural oil is combined with tonga, colchicum, black cohosh and pilocarpin, whereby the organs of elimination are greatly stimulated, so that prompt and efficient results are secured without the necessity of such large doses of the salicylates as to cause any harmful effects.

MARYLAND Medical Journal

Medicine and Surgery



The Medical Journal Company

BALTIMORE

Publishers

WASHINGTON

Volume Fifty-Five
Number Four

APRIL, 1912

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ACCOMPLISHES SO MUCH IN THIS CLASS OF CASES,
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BALTIMORE

Medical Items.

DR. BENNETT BERNARD BROWNE of 510 Park avenue has been suffering with blood poisoning, due to a slight abrasion of the skin, incurred while operating.

DR. FRANCIS MILES CHISOLM has given up his offices at The Farragut, Washington, and will devote his entire time to his home office at 1032 Rhode Island avenue N. W., Washington, D. C.

DR. GEORGE W. DOBBIN of 56 W. Biddle street was operated on at the Mercy Hospital, Baltimore, for appendicitis. He is reported to be doing very well at the present time.

DR. JAMES MATTHEWS of Spokane, Wash., was a recent visitor to Baltimore.

DR. WILLIAM C. MARETT has resigned as a member of the medical staff of Bayview Tuberculosis Hospital, and has accepted a position as assistant resident physician at Whitehaven Sanatorium, Pa. He will take up his new duties June 1.

DR. JOSEPH BLUM, 1816 Madison avenue, who graduated at the University of Maryland in 1885, has retired from practice in Baltimore, and will make his future home in New York. Dr. Blum leaves Baltimore with many regrets, among which the severance of the ties with the medical profession here is most conspicuous, but these regrets are appeased by recollections of the most pleasant relations that have always existed between his medical friends and himself. Dr. Blum takes advantage of these columns in bidding farewell to the members of the medical profession of this city.

DRS. ADOLPH MEYER AND CLAPHAM PENNINGTON are visiting in Europe.

GOVERNOR GOLDSBOROUGH has appointed the following physicians as coroners: Drs. Thos. R. Chambers, David I. Maclit, J. Frederick Hempel, Elijah J. Russell, Harry C. Hyde, Michael A. Abrams, Harry C. Algire, Robert G. Davis and John G. Jeffers.

THE infant son of Dr. C. Hampson Jones died from peritonitis following tonsillitis, contracted by kissing a playmate with sore throat.

MARRIAGES.

VERNON FRANCIS KELLY, M.D., University of Maryland, '04, to Miss Laura E. H. Spangler, both of Baltimore, at Baltimore, March 7, 1912. The couple will reside at 3705 Falls road.

NAPOLEON BRYAN STEWART, M.D., University of Maryland, '10, of Delta, Pa., and Miss Edna May Revell of Anne Arundel county, Maryland, at Trenton, N. J., November 29, 1911. The couple are residing in Baltimore.

DEATHS.

HENRY SINCLAIR CASTLEMAN, M.D., College of Physicians and Surgeons, '82, at his office in Martinsburg, W. Va., March 1, 1912, of heart disease, aged 53 years.

THOMAS ROBERT DOUGHER, M.D., University of Maryland, '09, at Pittston Hospital, Avoca, Pa., of pneumonia, February 16, 1912, aged 27 years.

OSCAR PORZER, M.D., College of Physicians and Surgeons, '06, of Bloomfield, N. J., at the German Hospital, Newark, N. J., early in March, 1912, from malignant disease, due to the kick of a horse 14 years before, aged 41 years.

JULIUS LEVIN, M.D., University of Maryland, '05, at his home in Johnstown, Pa., February 12, 1912, from the effects of accidental asphyxiation, aged 32 years.

ANDREW HENDERSON WHITRIDGE, M.D., Harvard Medical School, '94, Johns Hopkins University Medical School, '98, of 840 Park avenue, Baltimore, at the Union Protestant Infirmary, Baltimore, March, 19, 1912, following an operation for stomach trouble. Dr. Whitridge was 41 years of age, and one of the best known of Baltimore's younger physicians. He had been ill intermittently since 1910.

JOHN GUY HOLLYDAY, M.D., University of Maryland, '68, of 714 Frederick avenue, extended, at his office, March 15, 1912, of pneumonia, after an illness of about a year's duration. Dr. Hollyday was an ex-Confederate soldier, and had practiced medicine in Baltimore for over 42 years, and was the most prominent physician in the section in which he lives.

EDMUND K. GOLDSBOROUGH, M.D., University of Virginia, '64, a surgeon in the Confederate Army, and a former practitioner of Baltimore, at his home in Washington, 1333 K street N. W., March 13, 1912, of heart trouble. Dr. Goldsborough was an author of note.

An Announcement

Battle Creek, Mich., February 21, 1912.

To Our Friends:

Upon February 16th, 1912, the Appellate Division of the Supreme Court of the city of New York reversed and set aside the verdict for alleged libel secured in December, 1910, by Robert J. Collier against the Postum Cereal Co., Ltd.

Since the original verdict, Collier's Weekly has published repeated attacks upon this Company. We have made no reply, preferring to await the decision of the courts.

This Company was sued for libeling Collier in a reply we published to a previous editorial attack by the Weekly. In that reply the Postum Co. questioned the motive of the Weekly in making such editorial attack and branded as false the charges made by the editorial, which editorial the court now construes as containing two specific charges, viz: as to using fictitious endorsements and erroneous statements as to appendicitis.

In deciding the case, Mr. Justice Miller, who wrote the majority opinion of the court, in referring to the editorial charges, said:

"I am unable to find in the voluminous record before us any evidence whatever of the publication by the defendant of such fictitious endorsement, and, to say the least, it is open to argument whether any of the defendant's advertisements could fairly be construed as making a claim that Grape-Nuts would cure appendicitis."

The Postum Co. insists that all it claimed in its advertisements was that the use of Grape-Nuts as a food—before the attack—and because of its easy digestibility, would in many cases ward off an attack of appendicitis.

The Appellate Court holds that Collier succeeded in "bridging over the weakness" of his case by introducing a large amount of irrelevant and improper testimony. In concluding, Mr. Justice Miller, speaking for the court, said:

"The error was fundamental and permeated the whole case, and it seems to me that we cannot sustain this judgment without virtually holding that in a libel case either party is at liberty to attack the other, wholly regardless of the issues in the case."

Yours truly,

POSTUM CEREAL CO., Ltd.

Excerpts.

CHAMOIS SKINS—SHEEP INSTEAD OF CHAMOIS FURNISH THE COMMERCIAL ARTICLE NOWADAYS.

IN presenting this article I shall endeavor to place before your readers a short, intelligible treatise on chamois skins from an experience in their manufacture and sale reaching over 25 years.

The name "chamois skin" is misleading. It originates from the chamois animal, the zoological name being *Rupicapra tragus*. These animals, as is well known, inhabit the European Alps and Caucasus Mountains, and resemble a goat or deer. They are very shy and difficult to find. Hunters will follow them for days over dangerous mountain passes until they finally bring their prey to bay.

THE CHAMOIS ANIMAL.

The animal is about the size of a goat or deer, of a dark chestnut-brown color, with the exception of the forehead, the sides of the lower joints and the muzzle, which are white. Its horns, rising above the eyes, are black, smooth and straight for two-thirds of their length, when they suddenly curve backward. Its hoofs are admirably adapted for taking advantage of roughnesses or projections on the mountain sides or on glaciers. The hair is long, thick and coarse.

The supply of skins from the chamois animal is, indeed, very limited. There would not be a sufficient quantity produced in five years to supply the demand for chamois skins for a single day.

I made inquiries during a recent visit to Switzerland about the probable annual crop of these skins, and learned that 5000 to 6000 skins are about an annual yield.

WHAT THE ACTUAL SKINS ARE.

What is known in the markets of the world as chamois skins is really an oil-tanned, sheepskin "flesher," or lining, as it is called in England.

The genuine chamois skin, when tanned in oil, is of a very soft and velvety texture, with a very thin epidermis or grain, which is readily removed by "buffing." The skin is also rather heavier than a sheep or lamb skin, which is usually employed for the manufacture of chamois. For all ordinary purposes, however, the oil-tanned sheep or lamb skin "flesher" is just as desirable as the genuine chamois skin.

To manufacture sheep or lamb skins into chamois leather, the first step necessary is to remove the wool, which is done by several methods. The one usually employed now is to paint the flesh side of the skin with a strong solution of sodium sulphite. This will loosen the wool in about 12 hours' time, so that it is easily removed either by pulling it off by hand or by scraping with a dull instrument. The sodium sulphite is then washed out and the skin immersed in milk or lime to swell it and also to remove small particles of wool which still remain. The skin is then put on a beam, and the legs and head cut off and otherwise trimmed to make it the proper shape. The head, legs and other trimmings are sold to the glue-maker for making glue. The beamsman also removes all the



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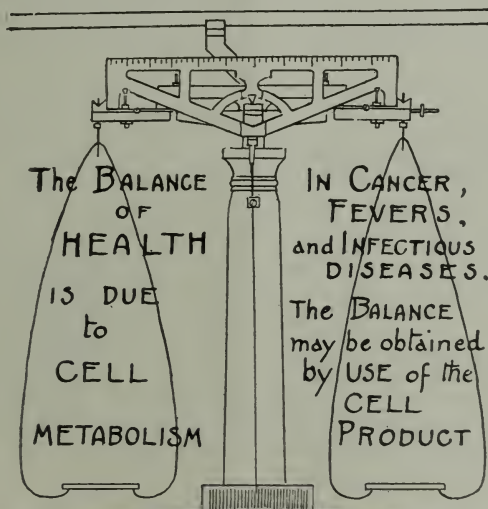
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flesh left on the skin by the poor workmanship of the butcher. After this the hide is ready for the splitting machine.

HOW MADE.

I wish to explain here that what is known in the trade as chamois skin is really only half of the skin. The outside portion—*i. e.*, that part of the skin next to the wool, known as the grain side—is not suitable for chamois leather, and is used for other purposes, mostly as pocketbook linings, hat linings and book bindings.

In former times, when skins were prepared for oil tannage, this part of the skin was cut away with a suitable knife and thus lost. To make chamois skins in this manner at the present time would mean at least double the price in the present market. At the present time the skin is cut through the center or split, thus producing two skins from one. The outside, that part of the skin next to the wool, is known as the grain side. The inside is called lining or flesher.

The splitting is accomplished mostly on machines especially constructed for this purpose. It consists of endless knives the edges of which are constantly grinding to keep them sharp, the skin being passed through rollers against the sharp edges of the knives. This machine requires delicate adjustment to produce good results.

THE TANNING PROCESS.

The lining or flesher is now ready for tanning. This is accomplished by sprinkling it with oil. Codfish oil of good quality is usually employed. It is very important that this oil should be thoroughly incorporated into the skin. For this purpose a quantity of the skins are placed into what are known as fulling stocks, which twist and turn in every direction and distribute the oil evenly.

After sufficient milling the skins are partly dried, and the process of sprinkling, milling and drying is repeated again and again until they are full of oil and all the moisture is dried out. They are now allowed to hang long enough to oxidize the oil in the skin at a temperature of about 100 degrees. The process after this is very simple. The oil is removed by pressure, a hydraulic process, and the remaining portions washed out by saponification with alkali. After this the skins are dried and are ready for finishing.

The oil which is removed from the skins by hydraulic pressure, also that portion of oil which is recovered by decomposing the soap solution with an acid and separating the oil, is used in the manufacture of other leathers, the object being to make the leather pliable, etc.

THE FINISHING.

The finishing is done mostly by pressing the skins against a revolving wheel covered with emery or flint. This removes all adhering substances and forms a finely-finished surface.

We now have the finished chamois leather ready for the trimming and sorting room, where it is cut into suitable sizes and packed for the market.

Of late years trimmed skins—*i. e.*, skins of even size—are preferred by the trade. For this reason most manufacturers, at least most American manufacturers, cut the skins over a pattern so as

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to produce uniform sizes. In former years, when England and France supplied the United States market, the skins in the same package would vary in size and shape, thus lacking uniformity.

It is true by cutting uniform sizes there is necessarily some waste, but this is reduced to a minimum when all pieces are again utilized by making watch bags and other small articles, which find a ready sale.

USES OF CHAMOIS.

The principal uses for chamois skins are for cleaning purposes. They will absorb moisture readily and give a high polish to glass, furniture and other highly-polished surfaces.

A good chamois skin can be used either wet or dry, and dry up soft when washed in soap and water.

Large quantities of chamois skins are also used for chest protectors, chamois vests, and even underclothes are made out of them for cold climates. Chamois skins are also used in the manufacture of many leather goods, such as purses, etc. Ladies use them for fancy work.

Of late years there has been placed on the market quite a quantity of imitation chamois skins to be used for fancy work and other purposes where the skins are not to be washed. These skins are usually produced by tanning the skins in alum and coloring them to imitate the genuine chamois. This will produce a skin looking very much like a chamois and very often having a superior finish to an oil-tanned skin. Care, however, should be used in selling these skins for ordinary purposes for which chamois is used. They will dry up very hard and stiff when washed. In ordinary chamois skins the dealer should order oil-tanned chamois if he desires a skin that is washable.

DIFFERENT KINDS OF COLORS.

Chamois skins can be made in all colors. Formerly colors were mostly produced by applying to the surface of the skins different colored pigments which adhere to the leather. This produces an unsatisfactory article, however, as it will always dust more or less.

Of late years, however, manufacturers have succeeded in producing fine colors with aniline, which is more satisfactory.

By incorporating a small quantity of ferric oxide, very finely powdered, an excellent polishing chamois is produced for silverware, etc.

A good quality of chamois skin is generally of a yellow or light-yellow color, which, when freshly cut, should show a dark-yellow color inside. This is a characteristic test of oil tannage. The absence of this color is generally an indication that the skin is tanned by a different method.

A good quality of oil-dressed chamois skin should also absorb moisture readily. This test is applied by allowing a few drops of water to fall upon the skin. It should absorb it speedily. If these drops roll about on the skin without absorption, it is almost a positive indication that it is not oil-tanned.

For some purposes a very light straw-colored chamois is demanded by the trade. These are produced by bleaching with sulphur. The skins, slightly damp, are hung in an air-tight room in which a small quantity of sulphur is burned, producing a light straw-colored product of bright color. It rather weakens the skin,

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however, and also incorporates some sulphur, which is objectionable when used in connection with silverware.

These bleached goods should not be used for wrapping silverware, as they are apt to tarnish it by producing sulphide.

The market affords a number of different brands of chamois skins. The principal ones are the American goods, the English and the French goods.

THE CARE OF CHAMOIS.

A good quality of chamois skin, when properly used, should last a long time, and can, of course, be used wet as well as dry. It is important, however, that chamois be kept clean.

HISTORY OF THE CHAMOIS INDUSTRY.

I may add that the manufacture of chamois skins in the United States has been attempted by various sheep-leather factories for the past 50 or 60 years with varying success, always resulting in abandonment. The first successful attempt to manufacture this article in a large way in the United States was accomplished by Drueding Bros. of Philadelphia. It was only by persistent efforts that the various difficulties in producing a satisfactory article in competition with cheap foreign labor was accomplished.

The duty on chamois skins has been only 20 per cent. ad valorem for a number of years.

Prior to 1883 practically all the skins consumed in the United States were imported from England and France. At the present time the importation has dwindled to a very small proportion. It seems, however, that this industry is not widely distributed, there being at the present time only three factories in the United States producing chamois skins.—*Bulletin of Pharmacy.*

Editorial Comment.

FEE SPLITTING.

Memphis Medical Monthly.

It has recently come to our attention that our profession is not the only one which is grappling with the problem of "fee splitting" and the "fee splitter." Our friends the lawyers have long poked fun at what they have been pleased to term our medieval code of ethics and our professional methods, seemingly tinged at times with strong sentimentality at the expense, as they make to believe, of good common sense. But it is now our turn to laugh, for they have fallen on troublesome times of their own. They have awakened to the fact that the "fee splitter" is among them with "his tricks that are wise and ways that are vain." The lawyers have found that certain of their number are willing to accept fees charged for and collected by other attorneys without the knowledge or consent of the client. What is still worse is the charge made by our legal brethren that some of their leading lights are willing to give a percentage to other attorneys who refer business to them. Recognizing this evil, the committee on professional ethics of the New York County Lawyers' Association has recommended to the board of directors a proposed code of ethics for the legal profession. The following is the section pertaining to "fee splitting:"

"He (the lawyer) should not accept any costs or compensation for services rendered in his client's matters without his client's

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knowledge, and he should not, without his client's knowledge and consent, accept any portion of the fees charged by other attorneys or individuals or corporations employed by him in his client's business."

We doctors have truly a fellow-feeling for our legal brethren, and frankly say that we hope they will be more successful in eradicating the evil than we have been.

We are indebted to the *Long Island Medical Journal* for the following resolutions, which have been adopted by the Academy of Medicine of New York and the Medical Society of the County of Kings:

"*Resolved*, That the secret division of a fee or fees with any person or persons who may be instrumental in influencing a patient or patients to apply for operative care or professional advice is unworthy of any member of the medical profession.

"*Resolved*, That if such a division of fee is made by a member of the New York Academy of Medicine, it should be counted as of sufficient ground for the expulsion of the member.

"*Resolved*, That the council considers it its duty to investigate charges against members made on the basis of such division of fee, and on receipt of proof of offense the council may either permit the resignation of the person or expel him from the academy."

These resolutions have our heartiest endorsement. While still in the "swaddling clothes" era of our editorial life; while about us there clings the damp, dank odor of the editorial nursery, we have indeed practiced medicine long enough to feel the baneful effects of the practice of "fee splitting" and the "fee splitter."

It is bad enough for lawyers to engage in this practice, though, as a rule, they deal merely in dollars and cents. But if there is a more degrading spectacle on earth than that of a doctor who is willing to hawk his patient around to the highest bidder, we do not know what it is. No earthly consideration should move him in the choice of a consultant except the best interest of the patient. We feel that we may, with some show of propriety, discuss this subject, having for 13 years been either referring patients to other physicians (nine-tenths) or having patients referred to us (one-tenth). We have positive views upon the subject which we are willing to state in plain, clear language. Our pages are open to any reputable physician who wishes either to take issue with our conclusions or to elaborate them or to offer a remedy for the evil. Our position may be stated as follows:

We believe that a patient should know the final and ultimate disposition of every dollar that he pays for medical services. If a partnership bill is rendered, it should be itemized, stating the services rendered by each medical man in the case, with the particular charge therefor. However, if the bill shows only that it includes the services of both physicians, no harm is done the patient, for he has a perfect right to ask that the bill be itemized. But the best plan of all is this: Let each man render his own bill and attend personally to its collection.

It is perfectly plain that the above resolutions are directed against the secret division of a fee—a practice that puts human life in jeopardy and degrades both the physician who gives it and the one who accepts it.

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NATIONAL MEDICAL MEETINGS, 1912

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	Atlantic City, May 30-June 2, '12
" Acad. of Ophthalm. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill. G. Carl Huber, Ann Arbor, Mich.....	Niagara Falls, Aug. 23-22, '12 December, 1912
" Anatomists, Association of.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	Philadelphia, June 7-8, '12
" Assn. of Genlt. Urinary Surgeons.....	John Guy Monihan, 90 William St., New York.....	
" Assn. of Medical Examiners	Charles Lynch, Washington, D. C.....	
" Assn. of Military Surgeons of the U. S.....	H. C. Ernst, Harvard Medical School, Boston.....	Philadelphia, April 5-6, '12
" Assn. of Path. and Bacteriologists	Louis J. Mitchell, 132 N. Wabash Ave., Chicago.....	Chicago, Oct. 16-18, 1912
" Assn. of Railway Surgeons.....	E. C. Rogers, Fairbault, Minn.....	
" Assn. for the Stu. of the Feeble-Minded	Wm. W. Potter, 238 Delaware Ave., Buffalo.....	
" Assn. of Obstetricians and Gyn.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.....	
" Assn. of Official Surgeons.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.....	
" Assn. of American Physicians.....	Guy Hinsdale, Hot Springs, Va.....	Hartford, June 10-12, '12
" Climatological Society.....	James M. F. Winfield, Brooklyn, New York.....	St. Louis, May 23-25, '12
" Dermatological Association.....	J. W. Travell, 27 E. 11th St., New York.....	Baltimore, Sept. 12, '12
" Electro-Therapeutic Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.....	Baltimore, May, 1912
" Gastro-Enterological Association.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Gynecological Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryn., Rhin. and Otol. Society.....	J. E. Newcomb, 118 N. 69th St., New York.....	
" Laryngological Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago.....	Atlantic City, June 4-7, '12
" Medical Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medical Editors' Association.....	Charles G. Wagner, Binghamton, N. Y.....	May 28-31, '12
" Medico-Psychological Association.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill.....	
" Medical Colleges, Association of.....	Alfred R. Allen, Philadelphia, Pa.....	Boston, May 30-June 1, '12
" Neurological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	Atlantic City, June 12-13, '12
" Ophthalmological Association.....	Robert B. Osgood, 372 Marlborough St., Boston.....	
" Orthopedic Association.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	Atlantic City, June 10-11, '12
" Otological Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.....	Hot Springs, Va., May 29-31, '12
" Pediatric Society.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati.....	
" Physio-Therapeutic Association.....	Geo. M. Kober, 1819 Q St., Washington, D. C.....	
" Physicians, Association of.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	Atlantic City, June 4-5, '12
" Proctological Society.....	William C. Woodward, Washington, D. C.....	Washington, Sept., 1912
" Public Health Association.....	Percy Brown, 155 Newberry St., Boston, Mass.....	
" Roentgen Ray Society.....	Robt. G. Le Conte, 1530 Locust St., Philadelphia.....	Montreal, 1912
" Surgical Association.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Therapeutic Society.....	Hugh Cabot, 1 Marlborough St., Boston.....	New York, April 2-4, '12
" Urological Association.....	A. A. Lyon, M.D., Nashville, Tenn.....	
Assn. Med. Officers A. and N. of Confederacy	T. A. Murphy B. & O. Bldg., Baltimore, Md.....	
Balto. & Ohio Assn. of Railway Surgeons.....	Guy Ellison, London, England.....	
British Medical Association.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-22, '12
Con. of State and Prov. Bds. of N. A.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.....	
International Congress on Tuberculosis.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky.....	Chicago, Oct. 22-24, '12
Mississippi Valley Medical Association.....	Chas. Wood Fassett, St. Joseph, Mo.....	
Missouri Valley, Medical Society of the.....	A. W. Suiter, Herkimer, N. Y.....	
Nat. Con. State Med. Exam. and Lic. Boards	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.....	May, 1912
Nat. Assn. for Prevention of Tuberculosis.....	Dr. Ramon Guiteras.....	
Pan-American Congress, Fifth.....	John R. Bagby, Md., Newport News, Va.....	
Seaboard Medical Assn. of Va. and N. C.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Medical College Association.....	W. D. Haggard, Nashville, Tenn.....	Old Point Comfort, 1912
Southern Surgical and Gynecological Assn.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Southern Medical Association.....	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of Md., W. Va. and W. Pa.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo.....	Cincinnati, 1912
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	A. T. Mann, M.D., Minneapolis, Minn.....	
Western Surgical and Gynecological Assn.....		

LOCAL DIRECTORY

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This Issue by the H. K. Mulford Company Concerning Meningo-Bacterin
(Meningococcus Vaccine).

BACTERIN therapy is long past the experimental stage, and the immunizing effect of typho-bacterin, for instance, is thoroughly established, the results from its use being sufficient evidence of the worth of this method of controlling the spread of typhoid fever. Remarkable results likewise have followed the use of cholera-bacterin, and it is hoped that equally good results will follow the use of meningo-bacterin in controlling epidemics of cerebrospinal meningitis. While immunization with Meningi-Bacterin has thus far been used in relatively few cases, it is entirely reasonable to believe that it will prove a most valuable aid in the suppression of epidemics of cerebrospinal meningitis.

Like the other bacterins, Meningo-Bacterin is a suspension of the killed bacteria in normal saline solution (0.85 per cent.). The cocci are grown upon a serum agar for about 24 hours, then washed off and suspended in salt solution. They are counted by Wright's method to determine the number of cocci in one cubic centimeter of the suspension, then killed by heating to 60° C. for one-half hour. After dilution of the thick suspension with normal saline solution (0.85 per cent.), so that the

two strengths are obtained, the now completed bacterin is subjected to rigid erobic and anero-bic tests, to assure the absence of live germs or spores. Guinea pigs are also injected to be certain that there are no harmful substances in the bacterin. Trikresol (0.25 per cent.) is used as the preservative.

Meningo-Bacterin is polyvalent, *i. e.*, a number of different strains of meningococci are used.

Directions.—The usual site for inoculation is the arm at about the insertion of the deltoid muscle. The dose is given subcutaneously, and not into the muscle nor into the skin. An area about the size of a five-cent piece is painted with tincture of iodine. The syringe needle is plunged through this area. No after-treatment is necessary.

The complete immunization treatment consists of three doses given at intervals of from 5 to 10 days. The first dose is 500 million, the second dose 1000 million and the third does 1000 million.

For children, smaller doses should be used, according to weight. It has been suggested that the unit of bodyweight for a full dose be considered 150 pounds.

MENINGO-BACTERIN FOR IMMUNIZING IS SUPPLIED IN TWO DISTINCT STYLES OF PACKAGES.

First—For immunizing one person there are supplied three syringes, each containing the proper amount for injection, designated, respectively, first, second and third doses. The first syringe contains the initial dose of 500 million killed meningococci, and the second and the third 1000 million each. The contents of the first syringe are to be injected as the initial dose, to be followed 5 to 10 days later by the contents of the second syringe, and again 5 to 10 days later by the contents of the third.

Second—For immunizing 10 persons, Meningo-Bacterin is supplied in hospital or Board of Health packages, containing 30 ampuls or 10 complete immunizing doses. The initial doses (500 million killed bacteria) are contained in the ampuls with the red label; the second doses (1000 million killed bacteria) in ampuls with the white label, and the third dose (1000 million killed bacteria) in ampuls with the blue label.

In each case the first injection is 500 million (red label); the second 1000 million (white label) is administered 5 to 10 days later, and the third of 1000 million (blue label) is injected 5 to 10 days following the second injection.

No syringe is supplied with the hospital-size

package, since it is expected that physicians using the same will employ their own hypodermic syringe after sterilization. The method of withdrawing the vaccine from the ampul is to moisten the rubber top or cap with a drop of Liquor Cresolis Comp., U. S. P., or 5 per cent. solution of carbolic acid; push the needle through the drop of antiseptic on the rubber cap, and then invert the bottle and slowly withdraw the required amount for injecting, following the instructions for the three injections necessary as directed.

The H. K. Mulford Company also supplies Anti-Meningitis Serum prepared after the method of Flexner and Jobling, and they will mail upon request to the Philadelphia office Mulford Working Bulletin No. 8, on Anti-Meningitis Serum, giving a detailed and impartial review of the literature.

Would You Forget the Untoward Effects of Chloral and the Bromides?

THIS heading must possess much interest for those physicians who have widely employed chloral and the bromides, and who have never quite forgotten the dangerous possibilities attending their use. It is true they possess great therapeutic activity, yet occasionally evils of a greater or less degree have followed their use, particularly if it be long continued. A great many physicians have gotten entirely away from chloral and the bromides, finding in Pasadyne (Daniel's Concentrated Tincture of Passiflora Incarnata) the every good quality of the drugs above named and none of their bad effects. Pasadyne, for this reason, is superior to these drugs and may profitably be employed in their stead. No habit will follow its use. It is free from the toxic properties of chloral and the bromides. If you would forget the untoward effects of chloral and the bromides, resort to Pasadyne. A sample bottle will be furnished if application be made to the Laboratory of John B. Daniel, Atlanta, Ga.

Nutrient Wine of Beef Peptone.

PREDIGESTED BEEF is the foundation of Nutrient Wine of Beef Peptone, a palatable and serviceable liquid food. To protein and carbohydrates are added the stimulating properties of meat extractives. The physician will be pleased with Nutrient Wine of Beef Peptone in cases where the patient's stomach will not appropriate ordinary diet and where the digestive organs demand rest or assistance.

Natural Alkaline Water and Endogenous Prophylaxis

THE apparent impossibility of compelling the use of that simplest of all medicaments, *aqua q. s.*, is one of the most serious problems confronting the physician. He iterates and reiterates the truism that water in abundance is as necessary to health as food; that cleanliness of the internal economy is as essential as scrubbing the external; that the waste materials constantly banking up in the system are as surely and as deadly poisons as any that may be administered exogenously; that "rheumatic" pains and aches, insomnia, listlessness and many attacks of mental depression are directly traceable to the presence in the circulation and absorption into the tissues of toxins which may readily be disposed of by a sufficient daily supply of H_2O .

How shall we overcome this apparently widespread distaste to the right use of this simplest of all remedies? Prescribing or recommending the use of "water" is not sufficient, for, while water is water, as "pigs is pigs," there is as vast a difference in waters as there is in pigs.

A *Natural Alkaline* water is desirable; "pure," of course, and surely solvent and eliminant in its action. Most waters respond to these tests in greater or lesser degree. To secure prophylaxis, however, with the ordinary city or spring water requires the ingestion of vast quantities. To most people this is extremely disagreeable—in some cases positively dangerous—and to a great many is a physical impossibility, this being true of women in particular. To obtain a water that meets all the above requirements, one with real medicinal properties that may be used in moderate quantities with positive results, is the problem.

It is claimed and apparently proven by the experience of those physicians who have watched its action that Cloverdale Mineral Water, from the Cloverdale Mineral Spring in Cumberland county, Pennsylvania, fully meets the demand for "a first-class alkaline water"; that "it is at present one of the few mineral waters on the market which has a real, definite medicinal action." Sanitary examination shows it to be "pure," and its source fully protected from possibility of contamination.

Recent official analysis shows Cloverdale Mineral Water to be moderately mineralized; calcic, magnesic, sodic, bicarbonated with a positive alkaline reaction; "stable," for its mineral content shows a change of only six parts per million in over 20 years. Physical tests have

proven it to be an active diuretic, a mild aperient, a solvent and eliminant. Delightfully palatable and extremely "light," it may be administered freely without fear of attendant nausea or distress, being quickly absorbed and promptly eliminated.

Used merely as an adjunct to the dietary, beneficial results are bound to accrue, and it has proven a valuable addition to the armamentarium, correcting faulty metabolism and other forms of the so-called uric acid diathesis, functional inactivity and atonicity of the digestive and genito-urinary tracts, stimulating secretions and neutralizing hyperacidity, forming a very soluble urate easily eliminated and prophylactic of intestinal bacteria.

It is claimed that the most enthusiastic believers in the therapeutic efficiency of Cloverdale Mineral Water are to be found among those members of the profession who were at first sceptical; personal use and observation having convinced them of its value.

THE simple dietary that is at the same time highly nutritious is an essential to modern treatment, especially in the convalescent period. The problem is to secure the most nourishment for the patient at the least expenditure of bodily energy. The digestive and assimilative organs, as a rule, weakened by the processes of disease, not only are not capable of their wonted work, but require themselves prompt nourishment.

Grape-Nuts, made of whole wheat and barley, is famous among physicians and nurses as probably the most available food in the above circumstances, being readily absorbed (after the necessary, thorough mastication), and supplying all the nourishment of these great cereals, including the "vital" phosphates.

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Volume Fifty-Five
Number Five

MAY, 1912

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The *Clinical Record*, for Physicians' bedside use, will be sent on request to any physician who has not yet received a copy, together with samples of **Grape-Nuts**, **Postum** and **Post Toasties**, for personal and clinical examination.

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MT. WASHINGTON (MD.) SEWAGE DISPOSAL PLANT
COMPLETED.

By Dr. William J. Todd.

At a meeting of the citizens of Mt. Washington, held November, 1911, the question of developing a sewerage system with a sufficiently large disposal plant to take care of and dispose of the sewage from the watershed of Western Run was discussed. Fear was expressed that the project was too great and too expensive, and the interest of the property-owners too small to entertain such an undertaking.

To dispose of the sewage from a valley about four miles long, containing 4500 acres, and with a possible subdivision of 14,000 building sites; to build the necessary sewerage system large enough to dispose of all the sewage from this watershed for the next 50 years, was considered a dream too gigantic to be thought of at that time.

One of the speakers at the November meeting, speaking of the development of Mt. Washington, to Pikesville, to Ruxton, to Roland Park, to Arlington, said: "This will mean a large and prosperous community, and the health of this community will depend upon proper drainage, and we must prepare for it now, and dispose of it properly, or future generations will criticize and complain of our lack of foresight. * * * Baltimore City is now spending a large sum of money for a sewerage system in that City. How long do you suppose Baltimore City will be willing to take our sewage from Jones Falls, allowing it to pass through the City? The time has come to act; do not let us lose our opportunity, and let us realize that we are our brother's keeper."*

This dream has been realized; this development is nearing completion; the sewage disposal plant has been erected; the trunk lines of the sewer have been laid, and are being used by some of the property-owners.

Here is evidence of what energy, well directed, can accomplish in a short space of time—less than a year. Here is also an example and precedent for other suburban neighborhoods to follow. Create a healthy condition in your village by disposing of your sewage, protecting your homes, not allowing it to flow on your neighbor's property and into the streams flowing through the City of Baltimore. Clean up your village and thereby help to clean up and keep clean Baltimore City.

*Develop Sewerage Systems. *Maryland Medical Journal*, April, 1911.

Editorial Comment.

THE NATIONAL CONTROL OF NEW YORK QUARANTINE.

The Medical Record.

THE anomalous situation with reference to the administration of the quarantine of New York harbor has reached its climax of absurdity. The spectacle no less tragic than grotesque of the executive of the Empire State looking about for some one competent or willing to take the place of Dr. Doty, who with meager facilities has sturdily guarded the sanitary gateway of the Western

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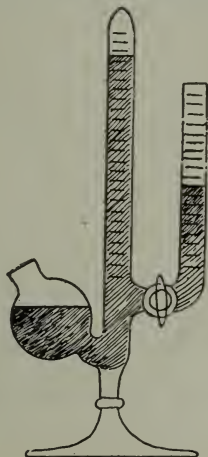
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World, can admit of but one interpretation. The State of New York can no longer be trusted by the nation to supervise the quarantine of its principal port. If there has ever been need for argument why the quarantine of any port should not be under Federal control, surely that need has vanished in the face of the object-lesson that had been lately unfolded. With the health officer of the port facing the insidious bearers of pestilence from abroad, and at the same time being compelled to defend his administration from the attacks of his political foes at home, it was an act of Providence that cholera did not gain a foothold in this country during the past summer. It should be a source of pride to Dr. Doty that during his incumbency of office the national government has never questioned his ability to defend the entire country from pestilential invasion.

But the quarantine of any port should not be left to the chance appointment of any man who may or may not be capable. The quarantine administration of the entire country should be systematized and uniform, with a machinery and a personnel perfected with the precision characteristic of the standing army or diplomatic corps. That machinery and that personnel exist today in the splendid organization of the Public Health and Marine Hospital Service, which is acknowledged even by foreign authorities to be unequaled by any similar organization in any other part of the world.

In the current issue of the *Survey* the editor makes a plea for the national control of the quarantine of New York harbor. This quarantine should be purged of political interference, should be uniform and standardized, adequate in its hospital and laboratory equipment, and capable of reconciling the interests of passengers and commerce with those of safeguarding the public health. In only three cities, Boston, Baltimore, and New York, is quarantine still under the obsolete system of State control, while in 44 other ports the national government exercises this supervision. Yet the most important port of the entire country, New York, through which pass in one year 800,000 persons, or three-fourths of the immigrants coming to this country, is left in the sanitary control of the local authorities. A large proportion of these immigrants are destined for parts of the country more or less remote from the port of entry. Why should the expense, the burden, the responsibility, and the danger of merely local supervision be tolerated in the most important gateway of the country, while the national government exercises this control in all the minor ports? Surely there is a precedent for the extension of this control to New York, for in 1892, when the cholera menace became most acute, the national government stepped in and took charge of the quarantine administration of New York harbor.

The safeguarding of the country from epidemic invasion from abroad is not a local function; it is national, if not international, in its scope. There should be a perfect co-ordination of activities throughout the country, with the assistance of the foreign agents of the public health authorities; with the utilization of all the sources of information, and the adoption of the most modern methods of quarantine supervision. This is possible only under Federal control. A movement with this end in view was inaugurated at a meeting of the Academy of Medicine. Recently when papers showing the advantages of the national control of quaran-

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time were read by Assistant Surgeon-General L. E. Cofer of the U. S. Public Health and Marine-Hospital Service, and Mr. William Williams, Commissioner of Immigration at the Port of New York. But one of the strongest arguments in support of such a move has been unwittingly furnished by Governor Dix.

DEATH OF LORD LISTER.

American Medicine.

The death of Lord Lister removes one of the world's great men. Unquestionably to him more than to anyone else the present status of surgery is due. While it is true that antisepsis has been superseded to a large extent by asepsis, it cannot be denied that Lister's comprehension of wound infection laid the foundation for modern surgical technique. To him, then, all credit belongs for the epoch-making studies which paved the way for the remarkable successes of present-day surgery. It is given to few men to witness the triumph of their ideas as Lister did. But, in spite of the general adoption of his methods, and the complete affirmation of his original views on the rôle of germs in the causation of suppuration, he never showed the slightest pride or self-appreciation. Although he must have realized the part he had played in the evolution of surgery, he never by word or deed gave any reason to believe that he expected any glory or credit for his achievements. Honors, to be sure, did come to him, and he lived to see his name and work esteemed by all mankind, but he never changed his manner, and to the last remained the humble, reserved and gentle physician, proud only of his profession and grateful for the opportunities it offered him to serve his fellow-beings. Although in his eighty-fifth year when he died, his life was still an active one, at once an example and an inspiration to his colleagues.

Joseph Lister, the pioneer of antiseptic surgery, was born at Upton, in Essex, in 1827, his father, Joseph Jackson Lister, F.R.S., being the inventor of the achromatic microscope. He was educated at a Quaker school in Tottenham, and lived from childhood in an atmosphere of scientific research. He received the degree of M.B. at the London University in 1852, and in the same year took the F.R.C.S. Eng.

After holding office for a time as a resident assistant in University College Hospital, Lister went to Scotland, where he remained, first as a supernumerary dresser under Mr. Syme, and afterwards as his house surgeon. On resigning his post, in 1850, he married Mr. Syme's daughter, and was soon afterwards appointed assistant surgeon to the Edinburgh Royal Infirmary. In this position he began to teach, as a private lecturer, on surgery recognized by the university, and continued to do so until his appointment to the chair of surgery in the University of Glasgow in 1860. He had already contributed a series of important papers to the Royal Society, papers chiefly based upon microscopical research, and in 1860 he was elected a fellow. In 1863 he was appointed by the Society as Croonian lecturer, and selected as his subject "The Coagulation of the Blood." About the same time he was a contributor of the articles on "Anesthetics" and on "Amputation" to "Holmes' System of Surgery," and had written other papers of very considerable merit.

Quoting from the *Medical Press and Circular*:

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Pasteur, whose two great hypotheses—that putrefaction is caused by the agency of living germs, and that these germs are not spontaneously generated—Lister made his own and converted to unthought-of uses, with what results are well known not only to the whole medical profession, but also to the whole civilized world. Focussing his giant intellect upon one great object, how to protect wounds from germs of inflammation, he devised the carbolic spray and carbolic gauze, or the Listerian bandage, as it was then called. The effects upon surgical mortality were striking and immediate, no such curative results having been previously obtained. In consequence, operations of much greater magnitude were undertaken with confidence by surgeons which formerly none would have dared to perform. The system soon spread, and was speedily taken up in Germany as well as in this country. Another great advance in surgical art is also associated with Lister's name—the use of the absorbable catgut ligature, which he introduced as a substitute for the silken or flax thread hitherto exclusively used. The work, which had been commenced in Glasgow, was transferred to Edinburgh in 1869, Lister in that year succeeding his father-in-law, Professor Syme, in the chair of clinical surgery in the university of the last-named city. In 1877 an opening was made for him at King's College, London, and he consented to go there as professor of clinical surgery, a post which he held until 1893, by which time his work was practically done, and the splendid service which he had rendered to mankind could no longer be questioned or concealed. The honors that awaited him were, perhaps, of little importance compared to his high services, but they were never more justly bestowed. On Mr. Gladstone's recommendation he was, in 1883, made a baronet, and in 1897 he was raised to the peerage. In 1902 he was appointed a member of the newly-instituted Order of Merit, as well as a P. C. From 1895 to 1900 he was president of the Royal Society. He was sergeant-surgeon to Queen Victoria and to King Edward, and has been president of the British Association for the Advancement of Science." His other scientific distinctions are too numerous to give in this brief outline of his career.

As someone has said, it has fallen to the lot of no other man of recent times to exert such a profound influence on the welfare of all humanity. Through the introduction of his methods and the subsequent researches which his announcements opened up, Lister has not only saved countless lives, but he has reduced human suffering to a wonderful degree.

With his passing, therefore, much as everyone must regret the closing of his career, there comes a feeling of heartfelt gratitude that a man whose life has meant so much to humanity lived in our age and time.

Although ennobled by a grateful sovereign, his work and the fruits thereof gave a nobility to Lister's life that will be remembered long after his title has been forgotten. Indeed, as long as men shall live the memory of Lister will endure as the one who freed mankind from the tyranny of germs—the bondage of infection. May he know the peace—and rest—that passes all understanding!

Transmitters of ——— ?



Many cases of throat trouble have been traced to the telephone. Many transmitters are noticeably dirty and mal-odorous.

The hard rubber mouth-piece can be kept clean and odorless if frequently wiped with a cloth moistened in

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SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	Atlantic City, May 30-June 2, '12
" Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	Niagara Falls, Aug. 20-22, '12
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1912
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	Philadelphia, June 7-8, '12
" Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York..	
" Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston..	
" Assn. of Railway Surgeons.....	Louis J. Mitchell 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
" Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo....	
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" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York....	Hartford, June 10-12, '12
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	St. Louis, May 23-25, '12
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	Baltimore, Sept. 12, '12
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	Baltimore, May, 1912
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago....	Atlantic City, June 4-7, '12
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	May 28-31, '12
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
" Medical Colleges, Association of.....	F. C. Zapfe, 1764 Lexington St., Chicago, Ill....	Boston, May 30-June 1, '12
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	Atlantic City, June 12-13, '12
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia....	Atlantic City, June 10-11, '12
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	Hot Springs, Va., May 29-31, '12
" Otolological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C....	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	Atlantic City, June 4-5, '12
" Public Health Association.....	William C. Woodward, Washington, D. C.....	Washington, Sept., 1912
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass..	
" Surgical Association.....	Robt. G. Le Conte, 1530 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
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British Medical Association.....	Guy Ellison, London, England.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-22, '12
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky....	Chicago, Oct. 22-24, '12
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Sulter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis..	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	May, 1912
Pan-American Congress, Fifth.....	Dr. Ramon Gutierrez.....	
Seaboard Medical Assn. of Va. and N. C.....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn.	A. T. Mann, M.D., Minneapolis Minn.....	Cincinnati, 1912

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sandner & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sandner & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

The Manufacture of Antitoxin.

In the treatment of diphtheria the physician of today uses antitoxin as a matter of course. It is his first expedient and his last resort. He believes implicitly in its efficacy. But does he understand and appreciate all that is involved in the production of that antitoxin—the scientific knowledge, the skill, the caution, the minutiae of detail? This thought is forced upon the writer through the perusal of a recent publication of Parke, Davis & Co., which deals in part with the subject of antitoxin manufacture. Here is a specimen chapter:

"In the selection of the horses which are to act as the living laboratories for the production of the antitoxin, we apply not commercial or academic knowledge merely, but, what is more to the point, veterinary skill. The animals must be vigorous and healthy. They are carefully examined, their temperature noted for several days, and the presence of glanders excluded by the delicate mallein test. It is the blood-serum of these animals that is to be injected into the patient later on, and no precaution can be regarded as extreme which contributes the slightest positive assurance of its purity.

"Not only must the horses be in good general condition when inoculated; they must be kept so. They are fed, stalled, groomed and exercised for no other purpose than to maintain to the full their self-protective, antitoxin-producing powers. Thirty miles removed from the

noise, smoke and dust of the city is our stock farm, equipped with model stables and supervised by expert veterinarians. Here, at Parkedale, on more than three hundred acres of sunny slopes, at an altitude of six hundred feet above the level of the Great Lakes, live the horses which we employ in serum-production. Amid these favorable surroundings they maintain the physical condition so essential to satisfactory service as serum-producers.

"These are preliminary considerations. Young, healthy, well-kept horses, indispensable as they are, would be of little use in the elaboration of a reliable antitoxin unless the work of injecting them with toxin were conducted accurately, aseptically, systematically, and throughout a period long enough to allow physiological reaction up to the limit of attainable immunization. We have horses enough, so that there is no occasion to be in a hurry with any of them; the exact length of time required for complete reaction is determined in each individual instance by carefully scheduled observations.

"It goes without saying that in the preparation of the toxin and its injection into the horses, as well as in obtaining the blood serum, the most rigid bacteriological technique is maintained. The methods we employ agree substantially with those of Roux, Aronson and Behring, and are from first to last in charge of experts. The varying susceptibility of different animals, whether guinea-pigs or horses, to the diphtheria poison; the more or less rapid physiological reaction; the variation in strength of the antitoxic serum from different horses; the absolute purity of the finished products—these are all important and delicate questions demanding for their determination a high degree of skill and scientific accuracy of observation. These qualifications, in our judgment, outrank all other considerations in the work of producing a reliable anti-diphtheric serum."

The foregoing has reference to but a single step in the process of serum production, and affords but a hint of the safeguards with which Anti-diphtheric Serum (P., D. & Co.) is hedged about at every stage of its manufacture—conditions which enable the company to guarantee the purity and potency of its antitoxin.

Riding High in the Profession's Favor.

A CALMING agent that is riding high in the profession's favor is Pasadyne, or, as it was formerly known, Daniel's Concentrated Tincture of *Passiflora Incarnata*.

For a third of a century Daniel's *Passiflora* enjoyed the most extensive employment as a

calmative, and it was only to defend themselves from piratical firms, making spurious *Passiflora* preparations, that the distinctive name of Pasadyne was adopted.

Pasadyne is just exactly what Daniel's *Passiflora Incarnata* was for many years—the most effective and safest calming and soporific agent available. Particularly in the case of hysterical women is Pasadyne valuable, for it is free from disagreeable effects and no fear attaches that the formation of a habit will follow its use. It is unusually potent, and physicians employing it for the first time need have no hesitancy; they will be gratified with the results it will produce. A sample bottle will be furnished if application be made to the laboratory of John B. Daniel, Atlanta, Ga.

Plasmodial Anemia.

IN spite of the modern theory of the etiology of malaria and malarial affections (mosquito-borne infection), this plasmodial disease continues to be rife in certain sections of the country, and bids fair to be, like "the poor," "always with us."

Every physician of experience appreciates the principles which should guide him in the treatment of the various acute manifestations of paludal poisoning, *i. e.*, the destruction of the plasmodial hosts which have invaded the blood, and which, if not eliminated, consume and destroy the red cells, the vital element of the circulating fluid.

When this purpose has once been accomplished the patient is but partly cured; the damage done to the red corpuscles must be repaired and the vitality of the blood restored if re-infection is to be avoided. If there is any one condition in which direct hematine or blood-building therapy is positively indicated, it is in Post-Malarial Anemia. As soon as the febrile period has passed, iron, in some form, should be given in full dosage. Pepto-Mangan (Gude) constitutes the ideal method of administering this essential blood-building agent in this as well as in any anemic condition. Both the iron and manganese in Pepto-Mangan are in organic combination with peptones, and are therefore easily and promptly absorbed and assimilated without causing digestive derangement or producing constipation.

The Conservation of Nervous Energy.

THE choice of a remedy that will prevent a continued dissipation of nervous energy is a matter of large importance, for there is a possibility in one's eagerness to use a drug which

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is therapeutically active, but insidious in its effect, to select one that is habit-forming. If this happens, no substantial gain has been made. A preparation which possesses potent therapeutic powers and yet is free from danger is Pasadyne (Daniel's Concentrated Tincture of *Passiflora Incarnata*). It exerts a markedly calmative influence in all exalted states of the nervous system, and is clearly indicated when the need for agents of its class arises. A sample bottle will be furnished if application be made to the laboratory of John B. Daniel, Atlanta, Ga.

Proper Support in Abdominal Displacements.

In displacements of the abdominal viscera, operation treatment is nowadays reserved only for severe and very obstinate cases, since it has been shown that much of the discomfort from which these patients suffer can be relieved from the wearing of a proper supporter. The "Storm" binder and abdominal supporter has been highly endorsed by many prominent members of the medical profession as an appliance constructed on anatomical lines, meeting all the requirements in cases of visceroptosis. Although this condition is particularly prevalent in women, displacement of the stomach, kidney or both, are not infrequently observed in the male sex and, according to the experiences of Dr. Charles G. Lucas of Louisville, Ky., these cases yield equally well to the use of a proper

abdominal support. He further states that "for the past two years or more I have used the supporter devised by Dr. Katherine L. Storm with decided success. The support given by secondary bandage of canvas and the light straps that encircle the thighs do away with all the objections to the old-fashioned bandage."—*International Journal of Surgery, January, 1912.*

A Cheaper Yet Superior Silver Salt.

AMONG the disadvantages attaching to some of the newer silver salts has been their cost. In Syrgol, an oxyalbuminate of silver, the profession has a highly effective germicidal agent, especially adapted for use in gonorrhea, and yet one whose cost is small. Syrgol is destructive to gonococci in solutions as weak as one-fourth or one-half of one per cent. It is unirritating and may be prescribed with every assurance that its action will be favorable. Before its introduction to the American profession, Syrgol was subjected to the most searching tests in continental hospitals and clinics. Under its use urethral discharge promptly moderates, the urine clears up, and complications need scarcely be reckoned with. Taking into consideration its undoubted merit as a gonococcicide and its small cost—since it is active in weak solutions—it may be said of Syrgol that it has no superior for use in gonorrheal disease. It is to be hoped that the American profession will try it out thoroughly.

Syrgol is prepared in the laboratory of the A. G. vorm. B. Siegfried of Zofingen, Switzerland, and is being introduced into America by Mr. Julius Schmid, Astoria, New York, who will be glad to supply American physicians with a liberal quantity sufficient to test its merit. Syrgol is carried in stock by all wholesale druggists.

Prevalent Diseases.

EACH change of season brings with it its diseases seemingly peculiar to the time.

Summer with its intestinal disorders, sunburn, insect bites, ivy poisoning, etc.

Fall presents for the attention of the physician its typhoid cases, and winter and early spring its regular quota of pneumonic, bronchial, throat and other chest conditions.

At this season, when pneumonia and bronchitis demand the call of the physician, literature presenting the experience of fellow practitioners in the successful handling of these cases would seem most apropos.

The Bloodless Phlebotomist for January re-

fects the experience of many physicians upon this timely subject.

Dr. Charles Buck of Cincinnati presents his experience in handling cases of pneumonia, also relates some facts in the treatment of lumbago, which might also be considered as an affliction prominently manifesting itself at this season.

"Broncho-Pneumonia," with supportive as well as local treatment in all its details, is the subject of the paper of F. A. Kautz also of Cincinnati.

Dr. E. Clinton Murray of Houston, Texas, relates his experience and treatment in a case of pneumonia in an 18-months-old baby, and Dr. J. C. Klippinger of Independence, Kans., presents a "Different Technique in Pneumonia," which is decidedly original. In abstract his method is to apply the local dressing in a manner which gives the intercostal muscles a chance to functionate without restriction from bandages. This symposium is closed with a paper from Dr. W. A. Radue of Union Hill, N. J., upon "Acute Pleurisy and a Successful Abortive Treatment."

Besides the papers referred to, upon the subject of chest and throat diseases much additional information is given. The one in particular we would have you note is the "Rational Influence of Hot Applications" by that well-known therapist, Dr. Finley Ellingwood of Chicago, Ill.

A postal card addressed to the Bloodless Phlebotomist, No. 57 Laight street, New York, will bring you a copy of the January issue.

FUNK & WAGNALLS COMPANY have secured the American rights to "A System of Surgery," edited by C. C. Choyce, dean of and teacher of operative surgery in the London School of Clinical Medicine (Post-graduate), etc. J. Martin Beattie, professor of pathology and bacteriology and dean of the faculty of medicine in the University of Sheffield, is the pathological editor of this important new work.

It will be published in three octavo volumes and profusely illustrated with colored, black and white and text illustrations. Each branch of surgery is treated by the foremost specialists in that particular branch in Great Britain, so that the work will really comprise the whole field of surgery from the viewpoint of the foremost British practitioners.

Volume I will be ready about the middle of April, and the remaining two volumes will be published about autumn, 1912. The price of the work will be \$21 per set.

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Let the children have all they want of Postum while their young bodies are growing and their nervous systems are getting "settled."

A PAD entitled "Prophylactic Memoranda" for physicians' use has just come to our desk. We believe it would be appreciated by the busy physician. The foreword, which is as follows and printed on each pad, explains its use.

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Editorial Comment.

DISAPPEARANCE OF PRIVATE PRACTICE.

American Medicine.

THE eventual disappearance of private practice seems to be accepted as a matter of course if we are to judge by the tenor of certain addresses by physicians of an observing and predicting turn of mind. The basis for the opinion is the gradual increase in the number of specialists as well as general practitioners who are under salary; investigators, teachers, pathologists, laboratory clinicians, hospital employes, life insurance directors, public health officers, military and naval officers, physicians to the poor, medical journalists, medical writers, advisors and investigators for pharmaceutical and chemical manufacturers, physicians to beneficial associations, missionaries, and we wish we could add public lecturers to teach hygiene and sanitation to laymen. There have been many references to the fact that the poor are beginning to think that when they are ill or hurt they are entitled to free treatment, including housing, clothing and food for themselves, as well as money to support the wife and babies. Whether it is right or wrong, they seem to be getting what they think their rights, and, as we have frequently remarked, society seems to be drifting to a socialism in which all doctors are salaried servants of corporations or society.

The future purpose of medical education is the point brought up by recent addresses on the decay of private practice. Medical colleges were first created to prepare students to enter private practice, but medical education has already become very largely a preparation for public practice or for something else. The teachers must adjust themselves to the new conditions or retire. Students must be prepared for a host of callings, and the colleges themselves must supply the demand, and not train students for private practice and then turn them loose to learn how to do the special work which modern civilization demands. Let us wake to the conditions at once, and recognize that a large and increasing percentage of students must be trained to other ways of earning a living than by private fees for advice to the sick. The welfare of society already demands that many should be specially trained to prevent sickness, and injury, too, for all accidents have had a medical bearing ever since we found out that they were mostly due to fatigue. Let the medical curriculum be arranged so that early specialization is possible and men are trained to take up these new lines of work.

The overcrowded medical curriculum is receiving long-needed attention at the hands of the Council on Medical Education of the American Medical Association. We have frequently called attention to the fact that we are forcing into the course more than the brain can hold, and now a great variety of suggestions are being made to standardize the colleges by establishing a minimum which each student must learn, no matter what his subsequent career. It is an age of minute division of labor and specialization. Physicians, willy-nilly, find themselves confined to very limited spheres of activity. The keynote for reform is not multiplication of studies for all, but specialization after the minimal rudiments are learned. Now, let us get at a reasonable estimate of what these minimal



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THAN ITS WEAKEST LINK.

IT IS NOT ENOUGH
TO DO THE DIGESTING
FOR THE STOMACH,
WE SHOULD PROPERLY
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rudiments should be. They will be merely a foundation for the later studies, which will and must assume the rôle of the technical training in engineering, for instance. A mining engineer is not the less efficient in his sphere if he is ignorant of shipbuilding, and a refractionist need know little of obstetrics.

LIMEWATER ONCE MORE.

Bulletin of Pharmacy.

MANY druggists are very careless about the preparation and handling of limewater. They seem to look upon the product as being of doubtful efficiency, anyway, and they fall more or less unconsciously into the habit of assuming that it doesn't matter very much whether the lime is present in full strength or not. Quite frequently, too, linewater is given away by druggists, and this custom contributes to the general attitude of indifference toward the substance.

And yet every once in a while an investigation is made, things are found not as they should be, and druggists are warned that they must mend their ways. Thus several years ago the Pennsylvania State Pharmaceutical Examining Board had samples of limewater purchased from 300 druggists. It was found on that occasion that 181 of the specimens were below the U. S. P. requirements. Many of them were less than one-half, less even than one-quarter, strength, and some of them were no better than hydrant water.

An interesting article entitled "Where Does the Average Druggist Get His Lime?" was contributed by Prof. Charles H. La Wall to the last meeting of the New Jersey Pharmaceutical Association. Professor La Wall explained that he had started out by selecting 12 prominent pharmacists—men who were leaders in association work. He had asked them two questions: First, "Where do you get your lime?" and secondly, "How do you test your limewater?" Five of the 12 men replied that they used a pulverized calcium oxide put up specially for the preparation of limewater; two others used another form of special lime; one man employed "selected building lime;" another got his material from the "nearest building operation;" another from the "lime dealer," while still another man declared that he got his lime anywhere he could.

So much for the lime employed in making limewater. As for the extent to which these 12 men tested the resulting product, Professor La Wall was very much discouraged to find that only one of them titrated the preparation by the U. S. P. method. Six of the 12 men practically declared that they did not test their limewater at all; three asserted that they tasted it; one man blew into it through soda straws, while another added solution of ammonium carbonate and noted the bulk of the precipitate.

Now, then, asks Professor La Wall, "If only about 8 per cent. of the leading professional pharmacists actually test their limewater, what percentage make use of the more complicated assay processes or quantitative methods of estimation of constituents indicating medicinal activity?" This question, as the Professor went on to explain, is one which has an important bearing upon pharmacopeial revision work, for the revisors are constantly endeavoring to so simplify all processes as to make them applicable

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by the average retail pharmacist. If the pharmacists are not going to employ them, what is the use of having them?

We venture the assertion, in partial reply to this indictment, that for reasons already mentioned the druggist is more careless in the preparation of linewater than he is with the great majority of products in his stock. There will be an awakening as the food and drug laws become more stringent and as the enforcement of them becomes more general.

LIGATION OF UMBILICAL CORD.

Memphis Medical Monthly.

MANY deaths from umbilical hemorrhage are reported every year to the National Bureau of Vital Statistics, and a few extremely simple rules are given looking to the avoidance of this usually preventable and (unfortunately) frequently fatal accident:

1. The cord should not (in the absence of hemorrhage) be cut until pulsations have nearly ceased.

2. The cord should be gently but forcibly stripped from the baby's umbilicus toward the placenta past the site of ligation. The cord should then be flat and bloodless. Tying a large knuckle of blood in the cord is frequently the source of pressure and consequent hemorrhage.

3. The cord should be neither too large nor too small. If too small, it will cut through its gelatinous tissues and cause hemorrhage. If too large, it will not knot properly, and thus cause hemorrhage. The best ligature is that made with coarse white spool thread, doubled, redoubled and twisted to the proper size. Silk suture material makes a poor ligature, as does catgut; tape is better, but not so good as the thread ligature.

4. The cord should be frequently inspected during the "physician's hour," that is, the hour immediately following the delivery. If, at the expiration of this hour, the cord is perfectly dry, with no signs of oozing, and if the ligature has been of the right size and properly applied, the probability of bleeding is most remote.

5. Oozing or blood loss, however slight, immediately demands prompt action, either by applying another ligature, or, this failing to control the hemorrhage, the umbilicus should be transfixed with a needle or transfixion pin and a figure 8 ligature applied. Relative slight blood loss in the new-born infant may prove fatal.

EDUCATIONAL UNREST.

American Medicine.

THE educational unrest is getting worse, and we hope it will become more so, for it is an indication that the results of our stupid methods are now causing so much pain that relief measures are imperative. Laymen have been saying of medical education a lot of things about which doctors have long been growling, and we feel mean enough to call attention to the gruelling criticism of universities at the hands of Prof. David Starr Jordan in his address on "The Making of a Darwin" (*Science*, December 30, 1910). Of course, Darwins and Agassizes are born, not made, but our own Osborn states that even if such a genius would wander into an American university, he would be extinguished by modern

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Dioxogen destroys the pathogenic organisms in milk but does not otherwise affect its chemical or physical properties: the curding and digestibility are the same as in untreated milk. Directions are *not* in the circular with the package; they will be sent together with a full report on request.

DIOXOGEN is of much higher purity than the U. S. P. standard; it is 25% stronger and contains less than 1/3 the solid residue allowed by the U. S. P.; the acid in Dioxogen is less than 1/5 that of normal fresh sweet milk.

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THE OAKLAND CHEMICAL CO.

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methods. It must be remembered that Darwin, Pasteur, Koch, Newton, Franklin and all other great discoverers owe their eminence to the fact that they were not in any university, but were free to do as they pleased with their facts and free to hunt what facts they pleased. Paul Ehrlich, the latest of the long list, could not even graduate, and, horror of horrors, in chemistry he was worst of all. He was always trying to do things differently than his teachers, who had never done an original thing themselves and were merely teaching him what had been taught to them. He was considered a failure as a student at the very time he was the best student of his decade. If education is merely pouring facts into the pupil's skull with a funnel, as the majority of teachers practice it, then we are training the memory alone; but if it is to be a real drawing out of mental faculties, then the graduate may be permitted to be as ignorant of old, useless facts as Ehrlich was—and the world profit by it. Let us think a bit over this matter and then realize that we want workers and thinkers, not memorizers. Our examining boards might take a hint, for while they must exclude the unlearned, they are suspected of asking too much learning and really rejecting some good men. Nothing but good can come of the present critical spirit, so let it continue to the end that education will fit the man, and not man the education.

THE STUDY OF WAYWARD GIRLS.

American Medicine.

THE study of wayward girls made in New York by the Episcopal Church Mission of Help has added more proof to what has been known since long before Lombroso so conclusively showed that they were the female counterpart of the male criminal. Each class comes from respectable families, as a rule, and as each is more or less mentally lacking, the problem is essentially a medical one to find out why they depart from parental type. The causes are mostly prenatal, but the environment after birth has a great deal to do with it. The reformatories have proved a thousand times over that the young criminal who through sheer weakness has bent to the evil influences of his environment can be straightened up if properly managed soon enough, and that he will keep straight, as a rule, when he is given this new strength, though, of course, there is no cure for his lack of mental development. The workers in the female field report equal success with wayward girls who are nearest the normal, but the worst are incorrigible.

REINFECTION WITH SYPHILIS.

American Medicine.

REINFECTION with syphilis may be expected with more frequency now that it seems probable that one attack does not confer immunity. When the first reports of salvarsan were published a few commentators were led to take a rather gloomy view of the effect on morals if the fear of contagion were removed. They have thus been answered much sooner than expected, for if a patient really is promptly cured, he may in a short time be just as liable to another attack as he ever was, and the check upon unbridled license is therefore undiminished. Indeed, there is nothing known yet as to the effect of repeated infections. It is entirely

CHEMISTRY IN THE TISSUES
 WHEN THOROUGHLY UNDERSTOOD,
 MAKES PLAINER THE **RAISON D'ETRE** OF
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 CHANGES IODINE UNDERGOES AFTER INGESTION, THROWS LIGHT ON THE CLINICAL
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I have never been disappointed in cases of itching hemorrhoids, and in many cases of eczema have had most flattering results. It will cure itching hemorrhoids and pruritus ani if used properly. I personally have been cured, and that caused me to use it on my patients.

I really can't speak too highly of its efficiency in the most distressing cases.

Yours very truly,

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Experienced physicians find that Ungt. Resinol is almost unfailing for the prompt control of itching, whether it arises from eczematous affections, from pruritus ani or vulvae, hemorrhoids, or other source. And, as this letter from Dr. Barber suggests, its continued use may usually be relied on to remove all traces of the trouble of which the itching was a symptom.

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possible that cures may be more difficult in such cases, and until we do know let us take it for granted that they will be. The disease has taken so long to cure that the cases of reinfection have been very few, and that has led us to believe that in the process of cure a real immunity to extra infection has existed as a result of treatment. Now that the active organisms can be destroyed before the body cells have taken on any kind of adjustment to their presence, we are confronted by an entirely different proposition. Even the blood tests now so popular may not show the presence of organisms which are practically hibernating, and we must go slow in the interpretation of positive or negative results. The whole matter of cure and subsequent susceptibility is so new and so involved that it will take a decade or two to clear it up. Twenty years hence these "cured" cases may be the subjects of extensive investigations by our alienists and neurologists, just as those "cured" by other means are now under observation and restraint. No! Morality won't suffer at all by salvarsan. That drug has made a deservedly big splash even if it doesn't cure a case, but the ripples are already quieting down. The immoral life is just as dangerous as ever.

DOCTORS COMPLAINING, TOO.

Bulletin of Pharmacy.

DRUGGISTS for years past have voiced their opposition to the gratuitous distribution of serums and other supplies by municipal authorities. They have no objection if the city furnishes antitoxin free to people who are really poverty-stricken. But they feel that not a few avail themselves of the privilege who are abundantly able to pay for the supplies.

Now the physicians, too, are beginning to complain about governmental interference with private practice. Too much medical service is bestowed gratis. Present standards of humanity make it easy for politicians in the big cities to establish hospitals for the free treatment of disease to the obvious injury of independent physicians not affiliated with the institutions. This is regarded as a downright imposition on the rights of the private practitioner just as much as the gratuitous distribution of serum is unfair to the pharmacists. In either profession years of study and expensive laboratory courses are required of candidates for a degree. No wonder they feel aggrieved if, after a lengthy training, the graduates find their functions usurped by a paternalistic Government.

It is distinctly un-American. As for charity, it is a question whether the recipients of such benefits are the better for them. Charity abused means injury to the poor as well as to the taxpayer. And as for the physician, his income is already sufficiently depleted by modern sanitation and hygiene without the health officers interfering in his cases. The regular city hospitals, too, are giving cause for complaint. Such institutions, where the well-to-do as well as the poor may enter, mean injury not only to the general medical practitioner, but also to the pharmacist. For too often the inmates are people of fair means who enter hospitals chiefly to avoid paying a doctor his fee and the pharmacist his drug bill.

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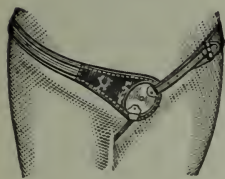
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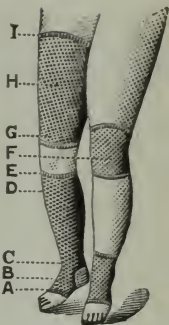
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" Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	Niagara Falls, Aug. 23-22, '12
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1912
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	Philadelphia, June 7-8, '12
" Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York..	
" Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston..	
" Assn. of Railway Surgeons.....	Louis J. Mitchell, 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
" Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
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" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	Hartford, June 10-12, '12
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York....	St. Louis, May 23-25, '12
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	Baltimore, Sept. 12, '12
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago....	Atlantic City, June 4-7, '12
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	May 28-31, '12
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" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	Boston, May 30-June 1, '12
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	Atlantic City, June 12-13, '12
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	Atlantic City, June 10-11, '12
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C..	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	Atlantic City, June 4-5, '12
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" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass..	
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" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	Montreal, June 6-8, '12
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
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Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-22, '12
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky....	Chicago, Oct. 22-24, '12
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	
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Nat. Assn. for Prevention of Tuberculosis..	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	
Pan-American Congress, Fifth.....	Dr. Ramon Gutierrez.....	
Seaboard Medical Assn. of Va. and N. C.....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn..	A. T. Mann, M.D., Minneapolis Minn.....	Cincinnati, 1912

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Pituitrin in Difficult Parturition.

MUCH attention is being given by the medical press of Germany and other European countries to the importance of Pituitrin as an oxytocic. The drug has been somewhat extensively used for the past two or three years both here and abroad, chiefly, perhaps, as a hemostatic and heart stimulant. Now it is known to be of great value in uterine inertia, obstetricians in many of the German hospitals and elsewhere who have thoroughly tested it clinically pronouncing it a truly remarkable oxytocic.

For the benefit of practitioners who may not be familiar with its origin and nature, it may be explained that Pituitrin is an extract of the posterior or infundibular portion of the pituitary gland. Although the physiology of this gland is as yet largely speculative, there seems to be no doubt that it contains a substance or substances that exerts a considerable influence over the metabolism and on the cardio-vascular system.

As bearing upon the value of Pituitrin in parturition, this expression from Dr. Emil Vogt of the Royal Gynecological Clinic at Dresden is significant:

"The oxytocic action of Pituitrin at this clinic was observed in over 100 cases. After the rupture of the fetal membranes in the second stage of labor the physiologic effect of Pituitrin is the most pronounced; the contrac-

tions of the uterus follow each other much more rapidly and energetically, and the intervals between pains are decreased. Individually, the pains are not more severe, so far as suffering is concerned, even in the case of sensitive women, than they would be in a normal delivery. In half of the cases the Pituitrin was administered in the second stage of labor. It failed only once; in all other instances its action was very pronounced. And although we encounter a great many cases of narrow pelvis in Dresden, from 40 to 50 per cent., it was not necessary to have recourse to forceps delivery in a single instance in which Pituitrin was employed. * * * According to our experience, Pituitrin is the ideal oxytocic."

Pituitrin is manufactured by Parke, Davis & Co. It is supplied in one-ounce bottles and in glaseptic ampoules (for convenient hypodermic injection), each ampoule containing one cubic centimeter, or 16 minims, the usual dose.

Parke, Davis & Co. have just issued a pamphlet on Pituitrin as an oxytocic, in which is reprinted not only the extract from Dr. Vogt which appears in this article, but also a number of others from prominent German specialists and practitioners, in which Pituitrin is highly extolled as a corrective of uterine inertia. Physicians will do well to write the company, addressing them at the home office in Detroit for a copy of the pamphlet.

The Prevention of Dysmenorrhea.

How can we prevent dysmenorrhea? It can be done by keeping the patient under morphine, but this is a barbarous solution of an important problem. It, in fact, does not solve it. Morphine is inadmissible and improper in these cases. It produces derangement of the secretions and tends to establish a drug habit that will make life a burden. I have long employed a remedy that not only relieves the pain, but produces no habit and is not dangerous. I refer to Dioiviburnia. It is a most valuable uterine tonic, antispasmodic and anodyne of exceptional worth. I rely upon this remedy to prevent dysmenorrhea, which, as Professor Davenport truly says, is seen in almost all, if not in all, women. I have my patients who suffer with dysmenorrhea to take Dioiviburnia, beginning two days before menstruation is due, and persist in it until the period has passed. I give it in doses of one to two teaspoonfuls every three hours throughout this time. When this direction is followed, I have found that my patients go through the period without pain.

The adoption of this treatment, I may say also, has brought me many grateful compliments. Where the patient is very nervous, having the tendency to hysteria, neuroses or uterine congestion, I administer Neurosine, one part in combination with two parts of Dioiviburnia, which always gives relief.—*L. G. Boyd, M.D.*

"Both in my practice in New York City, and particularly during the summer, when I am located at Richfield Springs, N. Y., a resort where thousands of rheumatic and gouty patients take the sulphur baths, I have prescribed Tongaline extensively, and it has always proved most satisfactory.

"I would state that, owing to the care and skill used in its manufacture, as also because it is always uniform and is well borne by the stomach, Tongaline stands foremost among the ready-made prescriptions for rheumatism, neuralgia, grippe, gout, etc. Besides, the conscientious practitioner hesitates about having such a complicated prescription as Tongaline prepared by a pharmacist, because even if the latter had fresh and pure ingredients, he has not the facilities to compound them properly, nor could he do so in any reasonable time."

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Plasmodial Anemia.

IN spite of the modern theory of the etiology of malaria and malarial affections (mosquito-borne infection) this plasmodial disease continues to be rife in certain sections of the country and bids fair to be, like "the poor," "always with us."

Every physician of experience appreciates the principles which should guide him in the treatment of the various acute manifestations of paludal poisoning, i. e., the destruction of the plasmodial hosts which have invaded the blood and which, if not eliminated, consume and destroy the red cells, the vital element of the circulating fluid.

When this purpose has once been accomplished the patient is but partly cured; the damage done to the red corpuscles must be repaired and the vitality of the blood restored if re-infection is to be avoided. If there is any one condition in which direct hematonic or blood-building therapy is positively indicated, it is in Post-Malarial Anemia. As soon as the febrile period has passed, iron, in some form, should be given in full dosage. Pepto-Mangan

(Gude) constitutes the ideal method of administering this essential blood-building agent in this as well as in any anemic conditions. Both the iron and manganese in Pepto-Mangan are in organic combination with peptones, and are therefore easily and promptly absorbed and assimilated without causing digestive derangement or producing constipation.

A PAD entitled "Prophylactic Memoranda" for physicians' use has just come to our desk. We believe it would be appreciated by the busy physician. The foreword, which is as follows, and printed on each pad, explains its use:

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THE value of heat as a therapeutic agent has been so conclusively proven that it will admit of no further argument.

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Convective heat is particularly applicable in cases where radiant heat is not indicated, and the reverse is quite true. Their differential thermic value is clearly set forth in the October issue of the *Bloodless Phlebotomist* along with an interesting paper by Dr. David MacIntyre, a Cunard surgeon, upon "Drugs at Sea."

In the same issue of the *Phlebotomist* Dr. Edward Parrish of Brooklyn presents his

methods of treating tic douloureux, and Dr. Leverett of Yonkers relates his experience in the successful handling of ivy-poisoning cases, which in many instances are quite as intractable to handle as tic douloureux.

In addition to these papers, much other interesting and instructive material is given, and it is worth while to write to the Denver Chemical Manufacturing Co., New York, for a copy of the *Bloodless Phlebotomist* for October, which they will send upon request.

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THE resorption of inflammatory exudates, such as those frequently following acute pleuritis, is accelerated by the administration of Idoneen (Curtis). It will be found that Idoneen (Curtis) for this purpose is more effective than the iodide of potassium, for its contained iodine (three per cent.), by reason of the ease with which it dissociates itself, thus permitting the most powerful of iodine effects, exerts an influence far in excess of what would be expected of this percentage. In practice, Idoneen (Curtis) is from fifteen to thirty times more active in iodine properties than other agents containing a similar percentage of the element. Idoneen (Curtis) will be found to influence all inflammatory exudates, aiding markedly in their resorption.

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SYRGOL, an oxyalbuminate of silver, has come into wide favor lately in Europe as a bactericide, and is now being introduced into America.

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has been especially recommended for use in gonorrheal infections, rigid clinical tests showing that it is highly efficient for this purpose. Besides its marked bactericidal properties, Syrgol possesses the added advantages of freedom from irritation and comparative cheapness. It is potent in solutions as weak as one-fourth per cent. Syrgol is prepared in the laboratory of the A. G. vorm. B. Siegfried of Zofingen, Switzerland, and is being introduced into America by Mr. Julius Schmid, Astoria, New York, who will be glad to supply American physicians with a liberal supply sufficient to test its merit. Syrgol is carried in stock by all wholesale druggists.

Discrimination in the Selection of Bromides.

A PROMINENT physician recently said: "It is a mystery to me why bromide of potassium is so generally used by the profession. Its action is not near as reliable as the bromide of sodium, and better still is a combination of the bromides. For such a preparation I use Peacock's Bromides, as I know it is made of the purest salts, and the difference between its therapeutic action and that of the commercial salts is very great. I have used it for years and it is always reliable and staple. It is impossible to obtain satisfactory results in prescribing bromide of potassium, and thus I have depended on this preparation. I have also learned that it is necessary to see that my prescriptions for it be filled at a first-class pharmacy."

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Excerpts.

NOTES, CHIEFLY THERAPEUTIC, ON VARIOUS DISEASES OF THE SKIN.

SCABIES.

DURING the Civil War and for some time afterward scabies was common enough; but from about 1870 until the end of the world's fairs and the Spanish War it had largely disappeared, except at seaport towns. This disorder is at present, however, fairly widespread over the whole country.

The usual way of treating scabies is by rubbing in sulphur ointment plain or in combination with some other drugs. There are slow methods and quick methods, but in private practice, at least, it is better to go slowly and be sure of a satisfactory result.

There is very little trouble in killing the itch mite with sulphur or other parasitocides, but it is sometimes rather difficult, to cure the patient's skin after he has been cured of the scabies. In other words, the treatment is generally by far too drastic, and results in a severe dermatitis with, perhaps, great suffering, and from which the patient may be weeks in recovering.

In the textbooks it is recommended that in the cases of quite young children sulphur in the strength of 10 to 20 gr. to the ounce of excipient is quite sufficient. Now, it is to be presumed that the itch mite is just as big when on the skin of a child as on the skin of a grown person, and if 10 gr. of sulphur will kill the acarus in the one case it will equally lethal in the other: therefore the massive doses for the adult are not at all necessary.

The point, of course, is that both in child and adult we should endeavor to get rid of the parasite with as little detriment to the host as possible.

In practice I have found the following plan of treatment generally satisfactory:

The patient is directed to take a hot bath at night with moderate frictions of green soap, preferably Bagoë's; on retiring he is to apply the following ointment and to repeat it morning and evening for three days, that is, six rubbings altogether:

R Sulphur præcipitati.....	5iii-vi
Balsami peruviani.....	5i
Vaselini.....	5iii

M. S.: Rub in one-half ounce night and morning. The druggist is ordered to furnish the patient a half-ounce box as a measure.

The salve should be well worked into the skin, particularly in those parts where the eruption is most profuse. The face should be carefully avoided; in fact the hands should be washed after these manipulations to avoid any contact of the sulphur with the face or eyes. It is best that the patient should put on fresh underclothes and lie between clean sheets before beginning the treatment, but he should make no change until the course is over.

If the treatment has been begun at night the sixth, or final, rub will occur in the morning; at bedtime a second hot bath, with green soap frictions is taken, the patient gets into clean clothes, and his bed linen is renewed. For perhaps a week longer a small amount of the same salve may be rubbed in at night at itching points. If the pruritis is more general—a sort of habit-pruritus—a zinc lotion with a small amount of carbolic acid may be prescribed. It is absolutely essential that the underclothing and

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sheets be boiled, else reinfection is more than probable. The outer garments may be ironed with a hot iron.

The strong irritants usually prescribed, containing heavy doses of sulphur, besides tar, green soap and chalk, often leave the skin greatly inflamed; but this unfortunate condition of affairs is not prone to occur when the mild and equally efficacious treatment outlined above is adopted. It must be confessed, however, that in nervous people a certain amount of pruritus remains for weeks, and is exceedingly obstinate. Sometimes this secondary affection, with its accompanying eruption, is somewhat suggestive of dermatitis herpetiformis.

Nervines, such as the elixir of the valerianate of ammonium, and lotions containing menthol and carbolic acid, are the best means of combating this condition, coupled with the assurance that the parasites themselves have been destroyed. It is rarely necessary to direct a second cycle of the sulphur inunctions.

If there are several members of a family similarly affected, it is obvious that all of them should undergo treatment simultaneously, else reinfections are likely to occur.

There is one very practical point which I have kept to the last, and it is this: If the ointment is not properly prepared, that is, absolutely free from all grittiness, it will do more harm than good, and this is true of any kind of salve that may be ordered, but particularly true of salves containing sulphur. The physician should, himself, see to this important matter.

SYCOSIS VULGARIS, AND IMPETIGO CONTAGIOSA OF THE BEARDED REGION.

Sycosis vulgaris, or folliculitis barbæ, is an extremely obstinate disorder, and in spite of the x-ray and vaccinothrapy and the older local applications, many cases resist all of our efforts to bring about even temporary amelioration.

So soon as the acute symptoms have subsided, all authorities agree that shaving daily, or at least every second day, is a *sine qua non* of successful treatment. I am quite persuaded of the importance of this procedure; but, curiously enough, I find no reference in the books to the necessity of doing this tonsorial operation aseptically. I shall return to this subject again when writing of other coccogenous affections, but I believe in treating sycosis it is necessary that the ordinary shaving brush and soap be discarded, that a cream rubbed in by the fingers should be used instead, and that the razor, etc., should be thoroughly sterilized. If these precautions are not observed, reinfection is bound to occur, and our best efforts are wasted.

In sycosis of the upper lip it is of course necessary to treat any nasal discharge by appropriate applications.

In subacute or chronic types of sycosis I have found what is known as Rosenthal's paste to give very good results. The original formula called for an extremely stiff paste that is very difficult to use, and I have modified it considerably in the following prescription:

℞	Acidi tannici.....	gr. lxxv
	Sulphuris præcipitati.....	℥iiss
	Zinci oxidi.....	
	Pulv. amyli.....	āā ℥iii
	Vaselini.....	℥iiss

M. S.: Apply twice a day.

Proper Diet

an important factor in

Summer Diarrhea

The composition of Mellin's Food shows that it is particularly adapted for the feeding of infants with diarrhea.

The maltose and dextrin in Mellin's Food

check the destruction of tissue-albumin by bacteria and furnish ample body-heat and energy. The easily utilized vegetable proteins in Mellin's Food supply enough nitrogenous food to maintain the baby's strength during the critical period.

Prepared in proportions of 2 level tablespoonfuls of Mellin's Food to $\frac{1}{2}$ pint of sterile water and given in small amounts at frequent intervals results in a rapid lessening of the frequency of stools and a marked improvement in their character.

Samples of Mellin's Food sufficient for a convincing trial will be sent promptly upon request.

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First, Anatomik Shoes will give perfect comfort from the start and prevent whatever foot trouble may be coming.

Second, Anatomik Shoes almost instantly relieve and permanently correct whatever foot trouble one may have.

Third, that while Anatomik Shoes prevent or correct foot trouble, they are good-looking shoes. They are of the highest quality in workmanship and leather.

Physicians can send their patients to us with the perfect assurance that they will receive prompt attention and that the Scientific Anatomik Shoe will give the foot the support properly required.

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It may also be mentioned in the interest of asepticism that the paste should not be taken out by the patient's finger, but removed by a bit of stick or toothpick, and then applied to the face with the finger, and smeared on in a thin layer without rubbing.

Sometimes this paste, even modified in this way, is too thick, and should be softened with a little oil of sweet almonds.

Impetigo contagiosa was at one time almost entirely confined to children, but it is now seen far more frequently among adult males, who get it from the barber shop, where it has found an apparently permanent lodging place.

In the interest of the public health the patient should not be allowed to return to the barber shop, but should shave himself, using the same precautions mentioned above.

I have often seen the disease kept up for long periods by neglect of these precautions.

Almost any weak parasiticide is effective, but it is well to remember that the crusts of the lesions should first be removed, and the salve thoroughly applied.

URTICARIA.

Acute attacks of urticaria are usually due to some irritating food, or some food for which the patient has an idiosyncrasy, and should be treated by giving an emetic and later an aperient. When sour fruit is the cause of the outbreak Whitfield gives at once 30 grains of calcium lactate in 2 ounces of anise water.

Chronic urticaria will tax the skill and patience of the physician to the extreme, but the details cannot be gone into here. I wish, however, in this place to call attention to the value of a method of management which I have found of great service in those cases of acute urticaria that are kept up by repeated exacerbations, last for several days, and induce the most exquisite local and general suffering.

The internal treatment consists in the administration of 5 or 10 grains each of a powder containing subcarbonate of bismuth and carbonate of magnesium every three or four hours, coupled with the liberal drinking of Vichy water, which should be fortified with a pinch of sodium bicarbonate on each occasion that the Vichy is drunk. I think it is necessary to insist on the subcarbonate of bismuth as the preparation to be used and not the subnitrate. The former is distinctly more calmative.

The local application of menthol, carbolic acid, tar, etc., give at least temporary relief. When carbolic acid, or the tincture of mineral tar is used, it acts best when sprayed on with an atomizer.

℞ Phenolis (vel tinct. picis mineralis) ʒii
Glycerini ʒss
Aquæ, q. s. ad ʒxvi

M. S.: Mop on with a rag or use as a spray.

A prescription containing menthol and carbolic acid added to zinc lotion (non-sprayable) is appended:

℞ Mentholis ʒi-ii
Alcoholis q. s.
Phenolis m.xx-xl
Zinci oxidi ʒiv
Pulv. calaminæ præp. ʒiv
Glycerini ʒii
Liq. calcis ʒii
Aquæ, q. s. ad ʒviii

M. S.: Mop on with rag.

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TWO teaspoonfuls of Dioxogen added to one quart of milk keeps it sweet for several days at ordinary summer temperature.

Dioxogen destroys the pathogenic organisms in milk but does not otherwise affect its chemical or physical properties: the curding and digestibility are the same as in untreated milk. Directions are *not* in the circular with the package; they will be sent together with a full report on request.

DIOXOGEN is of much higher purity than the U. S. P. standard; it is 25% stronger and contains less than 1/3 the solid residue allowed by the U. S. P.; the acid in Dioxogen is less than 1/5 that of normal fresh sweet milk. Dioxogen contains no acetanilid and undergoes no change with age; it is guaranteed not to exceed a loss of 5% in strength in one year; the wrapper of each package bears a perforated date of manufacture.

THE OAKLAND CHEMICAL CO.

NEW YORK

McIntosh's cream is sometimes better borne than any form of lotion.

R	Bismuthi subnitratiss.....	5ii
	Zinci oxidi.....	5ss
	Glycerini.....	5iss
	Phenolis.....	m.xx-xxx
	Vaselini.....	5vi

M. S.: Apply with finger or brush.

DERMATITIS DUE TO "WALNUT JUICE" HAIR DYES.

I must again beg leave to renew attention to a subject that I have referred to in another place.*

I am the more inclined to do this because I find that both the profession and the laity seem to be unaware of the ill effects of the so-called walnut hair dyes.

Recently Dr. Chipman of San Francisco published an interesting paper† on "Dermatitis Venenata from Proprietary Hair Dye," in which he reports a number of cases of dermatitis following the use of a certain "walnut tint" hair stain. It seems, however, that the action of this particular dye is due to paraphenylene diamin oxidized by means of a solution of hydrogen dioxid. Mewborn‡ had also called attention some years before to a similar preparation, and its deleterious effects are well known in France.

There are a number of "walnut-juice" preparations on the market, but whether they are all similar chemically to the one mentioned above, or whether any of them contains walnut juice I cannot at present say. This, however, I do know, that the very first case that I recognized in practice was the result of the application of a decoction of walnut hulls prepared at home.

Referring to this and other cases I said in my original paper that "the symptoms produced have been the same from both sources, so it is possible that the commercial dye really contains "walnut juice." The real point at issue is, however, that certain hair dyes purporting to be made from walnut juice are really very mischievous in their action, whether containing walnut juice or not.

I am constantly seeing cases of more or less pronounced inflammation about the face and head, which come to me usually with the diagnosis of eczema, and the history of long treatment both internal and local, where the real nature of the affection could have been divined by a little judicious investigation. The scalp itself is very rarely involved in the inflammation, the stress of the disease falling on the skin of the forehead, ears, face and neck, sometimes in one region alone, or in several; and also in varying degrees of severity. I must, however, refer the interested reader to the original article for the details of the symptoms present in these cases. The patient is directed to wash out the dye very thoroughly from the hair, and then to apply soothing pastes, salves or lotions, as may be required, to the affected parts.—*W. A. Hardaway, M.D., St. Louis (The Journal of the Missouri State Medical Society).*

*Inter-State Med. Jour., August, 1908.

†California State Jour. of Med., August, 1911.

‡Jour. Am. Med. Assn., May 18, 1901.

918 E STREET, N. W.
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April 19, 1912.

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(Signed) JAS. M. BARBER, M.D.

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Experienced physicians find that Ungt. Resinol is almost unailing for the prompt control of itching, whether it arises from eczematous affections, from pruritus ani or vulvae, hemorrhoids, or other source. And, as this letter from Dr. Barber suggests, its continued use may usually be relied on to remove all traces of the trouble of which the itching was a symptom.

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We should be glad to send you samples of these preparations.

Resinol Chemical Co., Baltimore, Md.

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as well as many other forms of abnormal cerebral excitation call for prompt and efficient sedation. That this is best afforded by

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is well known to countless physicians, since this dependable nerve and brain sedative accomplishes the desired results with gratifying freedom from nausea, or tendencies to bromism.

The purity, uniformity and therapeutic reliability of Peacock's Bromides have consequently given this product a well defined place in the modern emergency treatment—as well as routine therapy—of mental and nervous disorders.

Directions:—One to two teaspoonfuls in water every one, two or three hours as needed.

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Editorial Comment.

CONSERVATION OF CHILD LIFE.

The Journal of the Missouri State Medical Society.

CONGRESS is gradually coming to realize that its duty to the people includes an oversight of the health and living conditions of the human family. The hogs and the cattle, the fish and the birds, the plants and the trees, the soil and the rivers, are all safeguarded from wanton destruction by rapacious marauders; but the sancity of "personal rights" has so enthralled the nation that human health and life have been regarded as little more than a commercial asset, and those who trafficked in their waste not only have not been "regulated" but have actually been protected by law-making and law-interpreting bodies, as well as by the press.

The passage of the Borah child bill and its approval by the President indicates that a change has taken place in the popular mind as to what constitutes "personal rights," for with the approval of this bill child-life has become recognized as a proper governmental study. The bill creates a new bureau whose province will be the collection of statistics of all sorts concerning the living and labor conditions of children.

The bill was opposed bitterly by some members of the House and Senate on behalf of certain industries employing large numbers of young children, but despite this opposition the measure obtained a safe majority in both chambers by reason of its high importance as a public welfare measure. The reports of the investigations pursued by the bureau will be published by the Government from time to time.

The establishment of a bureau of this kind is a long step in the direction of health conservation and should have been created long ago. The next step—which should have been the first step in the scheme of health and life protection—is the passage of the Owen bill and the establishment of a department of health for the protection and conservation of all human life and health.

WAR ON MOSQUITOES.

The Journal of the Missouri State Medical Society.

THE St. Louis Health Commissioners recently pointed out the expediency of inaugurating a campaign this spring against mosquitoes in that city. At least \$30,000 will be necessary to initiate the movement, and more assistants and inspectors than are available at present will be required.

The city fathers who hold the money bags are loath to pass the necessary appropriation, whether from ignorance or indifference we cannot tell. But in the light of the immediate relief from malarial affections that the eradication of mosquitoes brings it is hard to figure out just how the city fathers of St. Louis can sidestep a matter so important to the health of the community.

The aid of the Boy Scouts has been promised, which will materially reduce the expense of additional inspectors in connection with the routine work of sanitation in the fight against mosquitoes, and we hope the municipality can afford \$30,000 in so sensible a cause.

Transmitters of ——— ?



Many cases of throat trouble have been traced to the telephone. Many transmitters are noticeably dirty and mal-odorous.

The hard rubber mouth-piece can be kept clean and odorless if frequently wiped with a cloth moistened in

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is an odorless, colorless liquid disinfectant and deodorizer. It is manufactured solely by Henry B. Platt, at New York and Montreal, and sold in quart bottles only, by druggists everywhere. Diluted with ten parts of water for moistening cloths and for general use, it costs less than five cents per quart.



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First Tuesday in June.

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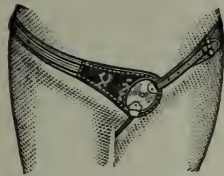
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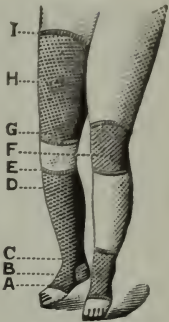
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NATIONAL MEDICAL MEETINGS, 1912

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	
Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	Niagara Falls, Aug. 20-22, '12
Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1912
Assn. of Genlt. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York...	
Assn. of Medical Examiners.....	John Guy Monihan, 90 William St., New York...	
Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
Assn. of Path. and Bacteriologists...	H. C. Ernst, Harvard Medical School, Boston...	
Assn. of Railway Surgeons.....	Louis J. Mitchell 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo....	
Assn. of Orficial Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.	
Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
Dermatological Association.....	James M. F. Winfield, Brooklyn, New York...	
Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	Baltimore, Sept. 12, '12
Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
Larynx, Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York....	
Laryngological Association.....	J. E. Newcomb, 118 N. 63th St., New York....	
Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago...	
Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill...	
Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia....	
Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati; O.	
Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C...	
Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	Washington, Sept., 1912
Public Health Association.....	William C. Woodward, Washington, D. C.....	
Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass...	
Surgical Association.....	Robt. G. Le Conte, 1530 Locust St., Philadelphia	Montreal, 1912
Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	
Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
Assn. Med. Officers A. and N. of Confederacy	A. A. Lyon, M.D., Nashville, Tenn.....	
Balto. & Ohio Assn. of Railway Surgeons...	T. A. Murphy B. & O. Bldg., Baltimore, Md...	
British Medical Association.....	Guy Ellison, London, England.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-22, '12
International Congress on Tuberculosis...	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association...	H. E. Tuley, 111 W. Kentucky, Louisville, Ky...	Chicago, Oct. 22-24, '12
Missouri Valley Medical Society of the...	Chas. Wood Fassett, St. Joseph, Mo.....	
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Suiter, Herkimer, N. Y.....	
Assn. for Prevention of Tuberculosis...	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	
Pan-American Congress, Fifth.....	Dr. Ramon Guiteras.....	
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Southern Medical College Association...	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	R. McKinner, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo...	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn...	A. T. Mann, M.D., Minneapolis Minn.....	Cincinnati, 1912

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sandner & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sandner & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Urotropin in Anterior Poliomyelitis and Meningeal Infections Generally.

THE advocates of the prophylactic and therapeutic use of Urotropin in anterior poliomyelitis and meningeal infections generally are constantly growing in number. Clinical experience appears to bear out the logical deductions of Cushing and Crowe (Johns Hopkins *Medical Bulletin*, April, 1908, and April, 1909), who discovered the excretion of Urotropin in the cerebrospinal fluid and first suggested its use in this field.

Among recent writers on the subject are:

Dr. Andrew L. Skoog, Kansas City, Mo., assistant professor of neurology, University of Kansas, who suggests that in anterior poliomyelitis the drug be given in as large doses as is safe over a period of a few hours and then discontinued for about 24 hours. His method is to give from 0.12 to 0.24 gramme to a child two to four years of age, giving a dose every hour until three doses have been given. No more is then given until the following day at the same hour, when it is repeated in the same manner. This repetition may be employed as long as acute symptoms persist. To adults he gives from 3 to 8 grammes of the drug during the daily three to four-hour period of its administration. (*Journal of the A. M. A.*, November 19, 1910.)

Dr. C. F. Clowe, Schenectady, N. Y., writing on the "Diagnosis and Treatment of Anterior

Poliomyelitis" (*N. Y. State Journal of Medicine*, November, 1910), describes 18 cases which had been reported to the Health Department of his city last summer. Three of the most severe were treated with Urotropin, and in these the recovery was more complete than was anticipated.

Dr. Alfred Friedlander, Cincinnati, Ohio, in an article on "Acute Anterior Poliomyelitis" (*Interstate Medical Journal*, November, 1910), reviews the most important contributions to the literature in 1910, and concludes that the early and free use of Urotropin is certainly advisable.

Editorial in *Colorado Medicine*, October, 1910, dealing with epidemic poliomyelitis, states that in addition to the usual symptomatic treatment it is strongly recommended by several clinicians that Urotropin be given as early as possible and in generous doses during the acute stages.

Editorial in the *Denver Medical Times* and *Utah Medical Journal*, November, 1910, under the heading of "New Facts About Poliomyelitis" emphasizes the fact that Urotropin tends to sterilize the cerebro-spinal fluid, and that if given early in full doses may prove to be of great value.

Dr. J. Ibrahim, chief physician of the Gisela Children's Hospital in Munich, Germany, reports in *Medizinische Klinik*, 1910, No. 48, the results of extensive experiments with Urotropin in the treatment of serous and suppurative meningitis in children, and advocates on the strength of his observations that Urotropin be used invariably in all forms of the diseases mentioned.

Dr. Walter Brem, chief of the Medical Clinic, Ancon Hospital, Ancon, Canal Zone, discusses in the *N. Y. Medical Journal* of October 22, 1910, the use of Urotropin in meningeal inflammation and reports a case of meningococcus meningitis in which he used it. The excretion of Urotropin in the cerebro-spinal fluid having been experimentally established by Cushing and Crowe, the author believes that this drug should be used promptly in all cases in which meningitis is a possible complication. When meningitis is already present it is indicated as an adjunct to the treatment or as a substitute for Flexner's serum when the latter cannot be obtained.

A Promising Agent in Hay Fever.

DR. J. E. ALBERTS of The Hague, Holland, undoubtedly performed an important service when he directed the attention of the medical profession to his new combination for the treat-

ment of vasomotor rhinitis. We refer to the combination now known as Anesthone Cream, which has heretofore been briefly noticed in these pages, and which contains one part of adrenalin chloride to twenty thousand (1-20,000), and ten per cent. of para-amido-ethylbenzoate, and is marketed in the form of an ointment.

Applied to the mucous membrane of the nares, Anesthone Cream has a persistent anesthetic effect which affords marked relief in hay fever. As para-amido-ethylbenzoate is only slightly soluble in aqueous fluids, its anesthetic action is prolonged. It does not have the poisonous effect of cocaine upon the protoplasmic element of cells, nor does it depress the heart. Furthermore, there is no tendency to "habit" acquirement.

The preparation came into considerable use during the hay-fever season of last year, the consensus of opinion being that it affords a very practical and satisfactory means of relief from symptoms due to hyperesthesia of the nasal mucous membrane, and without ill effects—an important consideration. The fact that the relief continues for several hours in some cases is worth remembering, in view of the fleeting effect of most local anesthetics.

Anesthone Cream is supplied in a collapsible tube with an elongated nozzle to facilitate its application to the nasal mucosa, a portion of the cream about the size of a pea being applied three or four times a day, as may be necessary. It is marketed by Parke, Davis & Co. Whether, as an agent in the treatment of hay fever, it will attain the vogue reached by some other preparations put out by the same company—notably Adrenalin Chloride Solution and Adrenalin Inhalant, which have been before the medical profession for a number of years and thus have the advantage which pertains to priority—remains to be seen. At any rate it is worthy of a fair chance, which, of course, in the long run it is certain to get.

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Dysmenorrhea As a Predisposing Cause of Neurosis.

FUNCTIONAL irregularities of the organs of generation, particularly if accompanied by pain, is possibly the greatest factor in the increasing number of women who consult the general practitioner presenting marked neurotic manifestations.

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The Return from the Country.

ALMOST every city family, whose exchequer will permit, is accustomed to spend a goodly

portion of the heated term away from home. This is both natural and salutary, provided good judgment is exercised in the selection of the country place or summer resort, as regards its general healthfulness and sanitary environment. Unfortunately sanitation on farms and in rural communities is not always what it should be, and the result is that many health and pleasure seekers return in the autumn depressed and run down or perhaps infected with malarial or typhoidal poison. In other cases, especially at crowded fashionable resorts, because of the continual round of exciting amusements, some are tired and fagged out instead of rejuvenated as the result of their summer's outing. Many are certainly in need of that general constitutional reconstruction and building up of force and resistance which is necessary to withstand the business or social strain of the fall and winter. In such cases there is no one single remedy quite as dependable as Pepto-Mangan (Gude). It increases appetite, restores strength and general vitality, reinforces the hemoglobin content of the blood and acts as a prompt and efficient general tonic and reconstituent for patients of all ages.

PROFESSOR DAVENPORT, in his admirable work on the Diseases of Woman, Dr. L. G. Boyd, Tunnelton, Ind., reviewing, adds:

How can we prevent dysmenorrhea? It can be done by keeping the patient under morphine, but this is a barbarous solution of an important problem. It in fact does not solve it. Morphine is inadmissible and improper in these cases. It produces derangement of the secretions and tends to establish a drug habit that will make life a burden. I have long employed a remedy that not only relieves the pain, but produces no habit and is not dangerous. I refer to Dioiviburnia. It is a most valuable uterine tonic, antispasmodic and anodyne of exceptional worth. I rely upon this remedy to prevent dysmenorrhea, which, as Professor Davenport truly says, is seen in almost all, if not in all, women. I have my patients who suffer with dysmenorrhea to take Dioiviburnia, beginning two days before menstruation is due, and persist in it until the period has passed. I give it in doses of one to two teaspoonfuls every three hours throughout this time. When this direction is followed I have found that my patients go through the period without pain. The adoption of this

treatment. I may say also, has brought me many grateful compliments.

Where the patient is very nervous, having the tendency to hysteria, neuroses or uterine congestion, I administer Neurosine one part, in combination with two parts of Dioviburnia, which always gives relief.

The Perils of Bronchitis.

It is for the aged and anemic that bronchitis has grave perils. The possibility of a severer infection grafting itself on the primary bronchial inflammation at once points to the wisdom of instituting treatment whose purpose will be to enrich the blood stream and add resistance to the tissues of the body.

Nutromul (Brown's Cottonseed-Oil Emulsion) possesses a peculiar fitness for this office; the prescriber may feel sure that the object of its administration will be fulfilled. Nutromul contains a large proportion of cottonseed oil, which is at last enjoying high favor as a reconstructive, and also the hypophosphites of lime, soda and manganese. It will aid materially in warding off the perils of bronchitis. A sample of Nutromul may be obtained by addressing Nottoc Laboratory, Atlanta, Ga.

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RICHARD C. NORRIS, M.D.

(Physician in charge of Preston Retreat; Gynecologist at Methodist Hospital, Philadelphia.)

"MALTOSE IN INFANT FEEDING" is the title of a very interesting pamphlet now being put into the hands of the general practitioner by the Mellin's Food Company.

It deals with the question of carbohydrates in the feeding of infants, giving opinions of

the comparative value of sugars employed in the modification of milk, and presenting much evidence of a convincing nature as to the superiority of maltose and dextrin for the carbohydrate content of a baby's diet.

Opinions of physicians whose extensive experience entitles them to a respectful hearing seem to show that these combined carbohydrates have a wide range of utility, giving results in intestinal disturbances and in the feeding of well babies that are highly satisfactory.

Requests for copies of "Maltose in Infant Feeding" addressed to the Mellin's Food Company, Boston, will have prompt attention.

MANY physicians have come to realize that caffeine, as daily consumed in coffee and tea, has much to do with the causation of many annoying ailments that formerly were obscurely diagnosed and vaguely treated. It stands to reason that this alkaloid, when taken in daily doses of six or more grains, must exert a harmful action on the nervous, circulatory and digestive systems. Its action must also modify the action of other drugs prescribed by the physician.

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Excerpts.

THE MANAGEMENT OF INFANTILE ECZEMA.

INFANTILE eczema is one of the most commonly met with of diseases of the skin and for that reason alone a consideration of the matter of dealing with it should be of interest, but when we further consider that it is also one of the most intractable of skin disorders, occasions such great disturbance of mind on the part of the family of the afflicted infant and brings so much undeserved discredit upon the attending physician, it at once assumes a position of importance quite out of proportion to its real gravity as regards both its immediate and its ultimate effects.

I have intentionally chosen the term management rather than treatment because success in dealing with cases of this kind involves not only supervision of diet, clothing, hygiene of the skin, choice and manner of application of remedies; but also the control or prevention of the kindly attentions of relatives and friends, all of which can scarcely be included in our understanding of the term therapy.

Success in dealing with this purely symptomatic affection of the skin will depend upon the degree of success we attain to in correcting the internal disturbance upon which it is dependent, and, whether the child be breast-fed or bottle-fed, its food must be carefully and rigidly regulated, as here usually is found the cause of the difficulty.

I wish, however, to emphasize the futility of attempting to deal with infantile eczema simply as a disease of the skin, and I am convinced that in each case there will be found some form of gastro-intestinal disturbance.

The benefit to be derived from external applications for the relief of any diseased condition of the skin is dependent quite as much on the manner in which the application is made as upon the choice of the remedy itself, and this is particularly true of eczema, in which the presence of crusts, scales and previous applications will, if not properly removed, preclude the possibility of benefit from remedies of any kind. So that water, so often spoken of as the thing to be avoided in eczema, is, if properly used, not only beneficial, but absolutely indispensable, the damage that results being due usually rather to strong soap than to the water itself.

Excess of zeal in cleanliness too is quite a common fault, as the removal of the natural protecting and lubricating secretions of the delicate skin exposes it to various forms of irritation. On the other hand, proper hygiene is essential, and every baby's skin should be kept free from extraneous matter of all kinds, but not at the expense of too vigorous use of soap and water. Water alone in any diseased condition of the skin will often irritate and should always be made slightly alkaline with borax or sodium bicarbonate. If crusts and dried secretions are firmly adherent a few hours' application of a poultice made from 5i each of starch and boric acid in one pint of cold water will render them easily removable. Remedies to be effective must be applied directly to the diseased surface, and this necessitates, of course, daily cleansing. Mild and soothing applications, either lotions or ointments, should be spread upon lint or thin layers of cotton and bound on firmly, merely smearing them on is usually unsatis-



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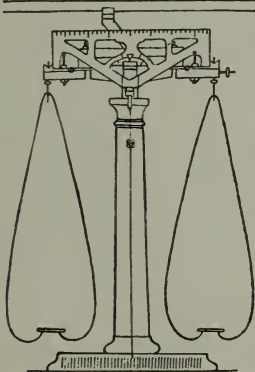
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factory, and for this reason the thick pastes are extremely useful as a base for other remedies, as they are quite adherent and may be put on in thick layers.

For the early erythematous eruption about the face a lotion as follows:

R Acid Carbolic gr. x.
Magnes Curb. $\bar{5}$ i.
Zinc Oxide $\bar{5}$ ii.
Glycerin $\bar{5}$ ss.
Aqua Calcis $\bar{5}$ ii.
Aqua Dest. $\bar{5}$ ii.

Applied two or three times a day with the conjoint use of a mild sulphur and salicylic ointment on the scalp to combat the seborrhea will be found usually sufficient if the toxic disturbance be also corrected.

If extensive weeping or oozing surfaces be present nothing is so effective and soothing as wet compresses of liq. plumbi subacetatis $\bar{5}$ i to a pint of cold water applied for twenty minutes three or four times a day and followed by the lotion above mentioned.

In more advanced cases, particularly those in which crusts have been allowed to accumulate, there is usually some considerable suppuration and mild antiseptics are necessary, of which ammoniated mercury 2 per cent. with salicylic $\frac{1}{2}$ per cent. in cold cream is one of the best and at the same time is of use in controlling itching. A few days' use of such an ointment will usually dispose of the suppuration, after which further treatment will depend upon conditions present.

In cases of some duration there is always a varying degree of thickening or induration of the skin, the removal of which requires much patience and considerable ingenuity. Tar is the most effective agent for this purpose, and to begin with may be used as in the following formula:

R Acid Carbolic.
Acid Salicylic aa Gr. iii.
Ung. picis liq. $\bar{5}$ i.
Lassar paste q. s. $\bar{5}$ i.

This is applied in a thick layer over night and removed in the morning, and the magnesia lotion kept on during the day. If benefit flags the salicylic acid may be increased to 1 per cent. and the tar gradually to $\bar{5}$ ii to the ounce. In markedly thickened areas and particularly if excoriated or fissured painting with 10 per cent. solution of silver nitrate is often followed by rapid improvement and can be repeated in four or five days. This is particularly true in the excoriated and fissured condition so often seen about the ears.

In the scalp the ointment of ammoniated mercury and salicylic acid with an occasional addition of tar may be used throughout the whole course of treatment, as ointments containing powders should never be used in the scalp because of the difficulty of removal, and here cleanliness is particularly essential.

Although infantile eczema in its typical form is ordinarily limited to the face and scalp, in long-standing cases there is frequently a more or less extensive involvement of other parts of the body, usually most marked on the arms and legs. The form of

Diarrhea of Infants

Mellin's Food, 4 level tablespoonfuls
Water (boiled, then cooled) 16 ounces

Analysis of above mixture:

Proteins (cereal)	-	-	.56
Carbohydrates (no starch)		4.33	
Salts	-	-	.23
Water	-	-	94.88
			<hr/> 100.00

Calories per fluidounce = 6.2

Maltose and Dextrin
Furnishes ample body-heat and energy
Spare the body-proteins
Maltose—most assimilable of all sugars
Maltose—least fermentable of all sugars

Give one to three ounces every hour or two, according to the age of the baby, continuing until stools lessen in number and improve in character.

Milk, preferably skimmed, may then be substituted for water—one ounce each day—until regular proportions of milk and water, adapted to the age of the baby are reached.

The use of this diet in diarrhea is a rational procedure and is in accord with present teachings.

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eruption is ordinarily the papular, with little or no tendency to weeping, but the itching is intense and demands relief. Ointments are rarely of service in the generalized cases and lotions and powders here find their greatest usefulness.

℞ Resorcin.
Sodii Boratis aa ʒi.
Glycerine ʒss.
Aqua Camphori ʒii.
Aqua dest. q. s. ʒiv.

May be applied two or three times a day and after drying, followed by a powder.

℞ Camphori pulv. ʒss.
Acid Boric ʒi.
Talcum pulv. q. s. ʒi.

More actively inflammatory or indurated patches should be treated according to the plans previously described.

Even a very limited experience in the treatment of infantile eczema will convince one that no single plan of procedure will apply to all cases or to any one case at different times; the disease is a most capricious one and demands the most careful watching and resourcefulness in handling, with frequent change in the composition of the external remedies used. It is better, however, to become familiar with the possibilities of a few remedies and to use them in varying strengths than to constantly be trying new ones.—*A. J. Markley, M.D., Denver.*

MALARIA IN PANAMA.

At a meeting of the Los Angeles County Medical Association, held October 20, Walter V. Brem presented a review of the prophylactic measures against malaria carried out in the Canal Zone, and discussed the subject of malaria in general (*Southern California Practitioner*, December, 1911). He pointed out that the multiple subdivisions of pernicious malarial fever were confusing, unnecessary, and often based upon misconceptions. As an illustration he reviewed the experience in Panama relative to the "dysenteric type" of pernicious malaria, and showed that such a type does not occur there, the apparently synchronous infections with the malarial parasites and *Bacillus dysenteriae*, being due to the lighting up of latent malarial infections by the dysentery. According to Brem, all pernicious malarial infections can be classified in one of the four following groups: the group of intense infection, the comatose group, the intermediate hemoglobinuric group, and the erythrocytic hemoglobinuric group. The author endeavored to show by means of experiments that erythrocytic hemoglobinuric fever is a manifestation of malaria. These experiments tended to reconcile the views of those who hold that blackwater fever is essentially malaria, and those who contend that it is due to quinine. The treatment of this disease by transfusion of normal blood, in the opinion of Brem, seems to be indicated. In the discussion that followed, A. H. Zeiler, who had worked with Brem in the Canal Zone, said he thought that hemoglobinuria, where the peripheral infection was 6 per cent. or over, was quite common, in fact occurred in nearly all cases. Such hemoglobinuria was usually not of the intensity of so-called

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blackwater fever. In the Canal Zone there has been plentiful experience of malaria in all its manifestations, and Brem and his coadjutors had under their observation at one time and another no fewer than 4691 patients suffering from malaria.

Editorial Comment.

THE METRIC SYSTEM.

The Therapeutic Record.

It is strange that an intelligent body of men like the medical profession would advocate the use of the metric system, when our present system of weights and measures is so ample and so familiar.

It would take almost a century for the public to familiarize itself with the metric system. In France, where it was originated, the system has never been assimilated by the general public and the former weights and measures are employed. The educated class of course understand the system, but the masses have thoroughly assimilated the old order and can not be brought to adopt the new for many years to come.

The metric system as a means of weights and measures in prescriptions is open to many objections. In the first place it is more complicated than the present method. In the second, the amount specified requires more words of characters than apothecaries weight. This is a serious objection.

Again, in order to order a dose of a drug like atropine or hyoscine an array of decimals is necessary, and these produce bulk and frequently confusion when this is unnecessary under the present order.

Certainly we ought not to invite confusion and possible errors. These creep into our work frequently enough any way, but why should we invite by a strange foreign system that is complicated and has nothing to recommend above apothecaries that we all have assimilated.

We earnestly hope that the metric system which has threatened for a generation to foist itself upon us will not gain a footing in the United States. In Great Britain it is true that many physicians use it, as many do in this country, but the general tendency there, as it is here, is to look upon the metric system as complicated and not suited for general purposes, and that there is no excuse for substituting it for one that is familiar and by no means complex.

ESOPHAGOSCOPY AND BRONCHOSCOPY BY THE KILLIAN METHOD.

Medical Record.

DR. THOMAS HUBBARD of Toledo reported a series of operations for removal of foreign bodies from the esophagus and the bronchi. (1) Boy aged 4. One cent piece in esophagus one month, complicated by stricture due to lye swallowed when two years of age. (2, 3) A group of coin and button cases were briefly referred to. Two cases having fragments of bone impacted in esophagus each

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five days, operated on by local anesthesia. One fatal case of impacted bone in esophagus one week; death due to pneumonia. (4) Girl aged 3 having a large open safety pin in esophagus. Details of method of turning the pin on the embedded point based on measurements of radiograph to determine the safety of this method. For instance, in the case detailed, the process of turning the pin by traction on the shield by means of a hook stretched the esophagus only one-quarter of an inch more than it was shown in the radiograph. This was done and no traumatism resulted. A snare was exhibited by means of which an open pin could be closed *in situ*. (5) Brass Christmas tree candle holder removed from the esophagus of an infant of 8 months. (6) A series of radiographs of a case having an upholsterer's tack in the left lung for eight years were exhibited, showing disappearance of the shaft and changes in the lungs. (7) Brass ferrule with rubber eraser in one end and a steel pen in the other, removed from the right bronchus. (8) Steel glass-headed pin removed from the left lower lobe bronchus of an infant after one week. (9) Screw bolt removed from right lower lobe bronchus of an infant after five days. (10) Fragment of cement tooth filling removed from the lower lobe, right lung of a woman, seven months after aspiration. During extraction of teeth this fragment snapped into the trachea. An abscess cavity formed and the fragment was located below the ninth rib near the spinal column and extracted through the Killian tube. A group of cases having kernels of corn, seeds, nutshell fragments, peanuts, etc., operated on in part by the Killian method were briefly referred to.

Abstract.

ON THE RADICAL REMOVAL OF THE CONDITIONS CAUSING ARTERIAL CHANGES LEADING TO NON-PSYCHOGENIC DISTURBANCES OF THE NERVOUS SYSTEM.

By Tom A. Williams, MB. CM. (Edin.), Washington, D. C.

THE vascular changes which lead to arterial sclerosis may show themselves in the brain at a period when blood pressure is not greatly elevated. The differential diagnosis requires special knowledge of neurological signs and is of great importance, because early treatment can accomplish so much. This is illustrated by three cases:

CASE I.—Focal epilepsy from necrosis of a small cortical sensori-motor area, diagnosed by slight reflex and sensory changes. The patient was well for over a year.

CASE II.—Psychasthenic depression in a man of 70, exaggerated by bereavements. No focal signs, but reflex disturbances. Cured definitively.

CASE III.—Psychasthenic depression in a powerful man in the prime of life, due to want of physical exercise and business worries. Cured in one month.

TREATMENT.—Special diet, poor in purins and restricted in nitrogen, with abundance of succulent and carbohydrate food alone, with moderate exercise. Psychotherapy is indicated.

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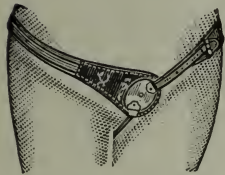
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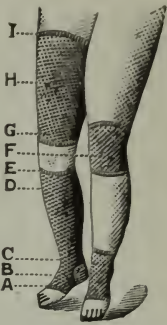
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SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa....	
" Acad. of Ophthal. and Oto-Laryngology ..	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	Niagara Falls, Aug. 20-22, '12
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1912
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York....	
" Assn. of Medical Examiners	G. Strohbach, M.D., Miami Bldg., Cincinnati, O.	Minneapolis, June 2-3, '13
" Assn. of Military Surgeons of the U. S. ..	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists	H. C. Ernst, Harvard Medical School, Boston..	
" Assn. of Railway Surgeons.....	Louis J. Mitchell 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
" Assn. for the Stu. of the Feeble-Minded ..	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo....	
" Assn. of Orificial Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York...	
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	Baltimore, Sept. 12, '12
" Gastro-Enterological Association.....	Chas. D. Aartrick, 32 W. Adams St., Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York....	
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" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
" Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill...	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia....	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C...	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	Washington, Sept., 1912
" Public Health Association.....	William C. Woodward, Washington, D. C.....	
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass...	
" Surgical Association.....	Robt. G. Le Conte, 1530 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
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Can. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-22, '12
International Congress on Tuberculosis...	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky...	Chicago, Oct. 22-24, '12
Missouri Valley, Medical Society of the...	Chas. Wood Fassett, St. Joseph, Mo.....	
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Nat. Assn. for Prevention of Tuberculosis...	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	
Pan-American Congress, Fifth.....	Dr. Ramon Guiteras.....	
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Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	Old Point Comfort, 1912
Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville, Tenn.....	Jacksonville, Nov. 12-14, '12
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	
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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

DR. H. ALBRECHT, first assistant to Prof. I. A. Amann at the Second Gynecological Clinic, Munich, Germany, in a paper read before the Munich Gynecological Society on June 17, and published in the *Muenchener Medizinische Wochenschrift*, No. 51, December 21, 1909, critically reviews the therapeutic significance of Collargolum at the hands of forty-five cases, which have been treated at the clinic in the past eighteen months and are representative of a great variety of septic infections. Of the four modes of administration—by inunction, per rectum, intravenously and per os—the author recommends only the gradual intravenous injection of 1 to 2 c.c. of 5-10 per cent. suspensions. He considers Collargolum a valuable therapeutic agent in cases of septicemia and pyemia of medium gravity, in severe resorptive fevers, accompanied by obstinate and enduring toxanemia, more particularly in all such cases, where in spite of local treatment and apparent localization of the infective process, unchanged high temperature and pulse indicate the presence of a deep-going tissue involvement and a progressive surcharge of the blood with toxins. In these cases the reaction is so prompt and distinctive that it is impossible to underrate the efficiency of Collargolum. According to the author, Collargolum should be given a trial in all cases of puerperal infection, because it is impossible to diagnose the gravity of the infection at the beginning, and also on account of

the prompt reduction of temperature and improvement of the general condition which it brings about. In very severe bacteriemia, in purulent peritonitis, parametritis exsudativa and in virulent localized suppurations, Collargol did not prove of value. The author emphasizes the usefulness of local administrations of Collargolum in acute cystitis and in pyelitis, as well as the now unquestionably proved innocuousness of the product. He does not ascribe antibacterial action to Collargolum and questions its leukocytogenetic properties, but believes that its efficiency is due to a catalytic action, consisting of ready absorption, accelerated oxydation and consequent decreased virulency of the toxins.

The Arrest of Chronic Bronchial Affections

THE arrest of bronchial inflammations which have taken on a chronic character, and which are gradually stealing from the tissues their normal resistance, is a matter of large importance, particularly so when it is remembered that it is but a short drift from chronic bronchial disorders to tuberculosis.

The longer such states exist the better is the soil prepared for a tuberculosis infection. It is easier and a far better practice to overcome the bronchial condition, and thus prevent a graver process, than it would be to manage the latter once it seized upon the weakened tissues.

Owing to its large value as a tissue nutrient and promoter of bodily resistance, Nutromul (Brown's Cottonseed Oil Emulsion) is being widely employed for the purpose of overcoming chronic bronchial conditions, and with the most gratifying results. Under its use the harassing cough stops, the bronchial mucosa approaches normal, and the patient takes on weight and strength. Cottonseed oil is proving its value as a nutrient and general reconstructive. The oil in Nutromol has been enhanced in therapeutic properties by the addition of the hypophosphites of lime, soda and manganese. A sample bottle may be had by addressing a postal card to Nottoc Laboratory, Atlanta, Ga.

The Hay-Fever Riddle.

DESPITE the many therapeutic advances of recent years, "what to do for the hay-fever patient" continues to be something of a puzzle. The long-sought specific still eludes us. Nevertheless, the malady is not quite the enigma that it once was. Medication, if still empiric, is not ineffective. The symptoms of the disorder can be controlled or minimized; relief, though tem-

porary in many cases, may be obtained; and for these blessings the afflicted patient and the sympathetic physician may well be thankful.

For use in the treatment of hay fever there is, of course, a long line of so-called available medicaments. One dependable agent which comes naturally to mind in this connection is Adrenalin. Indeed, it is doubtful if any other single medicinal substance has been so largely and successfully employed in the treatment of vasomotor rhinitis. As adapted to the needs of the hay-fever sufferer the product is available in a number of convenient forms, as Adrenalin Chloride Solution, Adrenalin Inhalant, Anesthone Cream, Anesthone Inhalant, Anesthone Tape, etc. The various solutions are used in spraying the nares and pharynx, the cream for snuffing into the nostrils, the tape for packing the nostrils. All cases of hay fever, of course, are not amenable to the same form of treatment. It is a logical presumption, however, that a vast majority of them ought to yield to one or more of the preparations above referred to. The Adrenalin products, as is well known to most physicians, are manufactured by Parke, Davis & Co., who will doubtless be glad to send literature regarding them to any practitioner. Requests for printed matter may be addressed to the company at its main offices and laboratories in Detroit, Mich.

From Schimmel & Co.'s Semi-Annual Report.

AFTER prolonged experiments Prof. Dunbar has been successful in discovering an effective mode of administering Pollantin as a remedy in the exceedingly troublesome form of asthma which afflicts certain patients in the later stages of hay fever. His process consists in compressing the finest sifted Pollantin-powder, together with sugar of milk and a suitable binding material, in the form of tablets, which are slowly dissolved in the mouth. Numerous patients to whom we have sent samples of the remedy for trial report that the tablets have afforded them the desired relief, but before we place the preparation upon the market we desire to collect further opinions, and we shall be pleased to place experimental samples at the disposal of the medical profession, and to receive reports on their therapeutic action.

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serum, and we therefore request them to look out such numbers, if any, from their stocks, and to send them to our Branch Office. Upon receipt the new tins will be forwarded by return. In reply to numerous enquiries, we may add that, as *powdered* Pollantin has unlimited keeping quality, it cannot be exchanged.

THE question of a light, nourishing easily-digestible food for those who require prompt help at the least cost of bodily energy is well answered in Grape-Nuts and cream. This famous food still holds its place in a class by itself. Made of whole wheat and barley, it affords the tissue-building albumins and energy-making carbohydrates of these cereals—the latter largely dextrinized and further converted into soluble sugars, for prompt assimilation.

Patients who have not yet regained their normal appetite or digestive powers are usually glad to avail themselves of the crisp, nutty granules of this clean, wholesome food, and the thorough mastication required is of itself a big help back to healthy digestion and body nutrition.

Syphilitic Cachexia.

IN the cachexia of syphilis, particularly during the late months of the disease, Cord. Ext. Ol. Morrhuæ Comp. (Hagee) has proven of much value, and is employed for this purpose in a routine manner by many physicians. Its

therapeutic power as a reconstructive in syphilitic cachexia rests upon its well-known property of improving bodily nutrition. Cord. Ext. Ol. Morrhuæ Comp. (Hagee) is a blood-maker of high order, a feature that makes it of particular value in syphilitic debility. Its employment will be of much aid to the usually resorted to therapy of syphilis and gratifying results will be noted from its administration.

Relief from Cerebral Agitation.

IN most instances the actual causative factor of extreme cerebral agitation is beyond the physician's power to correct, and all he can hope to accomplish with the means at his command is to pacify and procure for the suffering patient sleep. For this purpose he can use no agent with more definite properties nor one that is safer as a soporific than Daniel's Concentrated Tincture of Passiflora Incarnata, or, as it is now known to the profession, Pasadyne (a name adopted for convenience and to prevent substitution). Pasadyne will tranquilize the patient and bring about a deep, restful sleep, proving more efficient than chloral or the bromides. A still further advantage is its freedom from direct or indirect dangers, such as depression of vital functions or habit-formation. A sample, sufficient for trial, will be furnished any reputable medical practitioner if the request is sent to the laboratory of John B. Daniel, Atlanta, Ga.

An Announcement.

IT is with deep regret that we announce the death of our president, Thomas Doliber, on June 5, 1912. Mr. Doliber's business career covered a period of nearly sixty years. He was the founder of the Mellin's Food business in North America and for nearly forty years devoted his time and energies to its conduct and successful promotion.

MELLIN'S FOOD CO. OF NORTH AMERICA,
 Boston, Mass.

Collargolum and Unguentum Crede.

WRITING in the *Medizinische Klinik* of October 31, 1909, Dr. Michael Spitzer, assistant to Dr. Singer at the first medical ward of the Imperial Hospital, "Rudolfstiftung," in Vienna, says:

"Fully convinced that articular rheumatism, in the majority of cases, constitutes a pyemic process, Dr. Singer has for more than 10 years used Collargolum and Unguentum Credé in the treatment of this disease. Unguentum Credé

may be applied locally to the affected parts, or used percutaneously over a larger area, like mercuric ointment. Collargol is best used in form of enemata, $7\frac{1}{2}$ up to 75 grains in three to six ounces of distilled water being given. In a great number of cases where the smaller joints were affected excellent results have been obtained, although at times the remedy failed to produce improvement. Various other therapeutic agents are used at the hospital in the treatment of articular rheumatism, but in obstinate cases Dr. Singer, both in his private practice and at the hospital, always falls back upon argentum colloidal, giving preference to the Credé preparations."

The Palatability of Chologestin.

We are pleased to state that Chologestin, as now marketed, is so agreeable to the taste that no reasonable patient can object to it when *well diluted* with cold water. This has been made possible by improved methods of manufacture which effectually disguise the characteristic bitterness of the natural bile salt (Sodium Glycocholate) without reducing the dose or impairing its therapeutic efficiency.

We will be pleased to send samples to any physician who may desire same. F. H. Strong Company, 58 Warren street, New York.

Bile-Tract Infection and Gallstone Disease.

THE cholagogue, antiseptic and digestive properties of Chologestin and Tablogestin (tablets of Chologestin) serve to:

1. Overcome inactivity or torpidity of the liver.
2. Increase the formation and promote the flow of bile.
3. Liquefy and "thin out" the biliary fluid.
4. Relieve catarrhal and inflammatory conditions of the bile tract.
5. Increase the percentage of normal bile acids in the bile, hold the cholesterol in solution and thus prevent the formation of gallstones.

Incidentally, Chologestin (and Tablogestin) checks intestinal fermentation and putrefaction, and thus prevents and relieves intestinal auto-intoxication and toxicemic headaches.

When surgery is contraindicated, Chologestin (and Tablogestin) proves of distinct service in preventing attacks of hepatic colic.

After surgical interference, it serves, by virtue of its cholagogue action, to promote natural bile-tract drainage.

Chologestin (liquid) and Tablogestin (tablets of Chologestin) are therefore indicated in:

1. Hepatic insufficiency.
2. Catarrhal jaundice.
3. Catarrhal cholangitis and cholecystitis.
4. Prevention of gallstone formation.
5. Prevention of hepatic colic; also in intestinal dyspepsia generally, especially when associated with considerable fermentation or putrefaction, and in the intestinal auto-toxemia arising therefrom.

The Effective Treatment of Constipation.

GRADUALLY the profession are beginning to realize that Prunoids offer the ideal treatment for all forms of constipation traceable to functional causes.

They produce their results by stimulating normal secretions, rapidly increasing the fluid content of the feces and gently increasing peristalsis. They are extremely palatable, easily taken by even young children, and when brought in contact with the secretions rapidly disintegrate and produce their specific medicinal effect.

Probably the most gratifying feature of Prunoids is what for lack of a better term may be called their remote effect. While prompt and decided catharsis follows their administration in six or eight hours, a mild and salutary laxative influence is observed for several days after the final dose of Prunoids. Other cathartic measures act just the reverse, and after their use the bowels invariably show greater lethargy and sluggishness.

Feeding of Infants in Summer Diarrhea.

IN diarrhea or in pronounced digestive disturbances when milk is contraindicated, Mellin's Food dissolved in water, in proportions given in following formula, gives immediate and satisfactory results: Mellin's Food, 2 level tablespoonsful; water, 8 fluid ounces. To be given cold or very warm (never luke-warm), in small amounts, frequently repeated, for a day or more, or until stools lessen in number and improve in character. Then milk may be added in small quantities until full diet is reached.

Such a diet is much to be preferred to ordinary cereal gruels, as it is free from starch and contains enough nourishment, available for immediate assimilation, to carry the baby through the critical period. Send for samples and our book, "Formulas for Infant-Feeding." Mellin's Food Co., Boston, Mass.

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involving the gastro-intestinal tract or the circulatory system, are especially amenable to

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May be maintained by proper nutrition and tone; a long convalescence can be shortened, and anemia and emaciation prevented by

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Which contains the vital elements of nutrition and nerve tone, as indicated by the full, normal physiological standard, namely

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ORGANIC IRON
ALBUMINS

Write for Sample, also for one of our new Glass (sterilizable) Tongue Depressors.

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Conditions of Malnutrition

are exceedingly common among children and in their treatment a prescribed dietary becomes all-important. Drugs occupy but small place in the problem of treatment.

A simple and generally uniform diet is indicated covering food of right nutritive value, easily digested and promptly assimilated; for digestive symptoms if not constant are readily excited.

For years

Grape-Nuts

FOOD

has found high favor with physicians because of its peculiar fitness in such conditions.

Made of choice wheat and malted barley, (including the outer coat of the grain in the milling) the valuable organic mineral ingredients essential to tissue building are retained. As is well known, these are lacking in the impoverished product of the miller of white bread flour.

Long baking (from 12 to 16 hours) under thoroughly sanitary conditions, and the action of the diastase of the barley in the presence of heat and moisture, result in the conversion of a large portion of the starchy ingredients.

These processes of the manufacture of Grape-Nuts parallel, to a degree, the functions of the human digestive organs and produce a food well on its way to complete digestion.

The *Clinical Record* for physician's bedside use sent, prepaid, to any Physician or Nurse who has not already received one. Also a box of samples of Postum, Grape-Nuts and Post Toasties.

Abstract.

CASES ILLUSTRATING RATIONAL TREATMENT OF HYSTERIA WITHOUT MINUTE PSYCHO- ANALYSIS.

By Tom A. Williams, MB. CM. (Edin.), Washington, D. C.

Medical Annals, January, 1912, Post-Graduate July.

HYSTERIA is defined from its genesis—that is, by suggestion. Ten cases are described. They are divided into three types:

A. Where the causative suggestion is found to originate in some organic disease. This is the commonest type and the most practically important, because the hysteria often creates far more functional disability than does the disease which suggests it.

B. Cases in which the causative suggestion was not discovered because of insufficient psycho-analysis, but in which the secondary effects of the undiscovered suggestion which had become a habit were removed by psycho-motor discipline, and the tendency to further hurtful suggestions was minimized by psycho-therapeutic measures, consisting of the readjustment of the patient's point of view. These cases are not uncommon in practice, are rarely cured either by mediate or immediate suggestion, and require a knowledge of psycho-therapeutic technique for their successful treatment.

C. Cases of hysterizability, whether innate, from family predisposition or acquired, usually in childhood on account of improper upbringing and lack of education in self-control, and against impulsivity and inattention. These cases are in want of pedagogical as well as medical assistance, but as those who usually come to the doctor do so because their ailment is supposed to be physical, the physician must become pedagogue toward these patients, at least until the false ideas as to their physical states which have arisen from suggestion have been transformed.

Case I. The first example complicated a hematomyelia of two years' standing, but a single interview enabled the man, a machinist, to go to work, in spite of the organic defects.

Case II. Illustrates the failure of suggestive treatment to prevent relapses in a case of hysterical neuralgia.

Case III. The hysterical complication required separation from the results of an osteomyelitis, the effects of an injury and the dreamlike state produced by chronic alcoholism. This led to successful therapeusis.

Case IV. Hysterical appendicitis of three months, cured by her own doctor in two hours.

Case V. Coccygodynia, cured by her own doctor in four months, after failure of numerous surgical operations.

Case VI. A habit spasms of an ilio-psoas originating in a chronic appendicitis, cured by 10 days' psycho-motor discipline, subsequent to an operation which had not improved it.

Case VII. Intense hyperesthesia of the patellar regions, cured in a week by psycho-motor discipline, after several months' failure of powerful suggestions of various doctors.

Case VIII. Hysterical tic, cured in two interviews by psycho-motor discipline.

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Monosodium-Diethyl-Barbituric Acid

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SOPORIFIC EFFECT**

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Superior to the sparingly soluble diethyl-barbituric acid of Mering. Advantageously replaces chloral in threatening delirium tremens; useful in the treatment of morphinism.

Dose: 5 to 15 grains (1 to 3 tablets)

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Combines the action of valerian with that of bromine, but is readily taken and well borne, causing no eructation or other untoward symptoms. Exhibits

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Decidedly effective in neurasthenic and hysterical conditions, obviating subjective difficulties—mental and physical fatigue, headache, nervousness, insomnia, etc.

Dose: 1 to 3 pearls several times daily

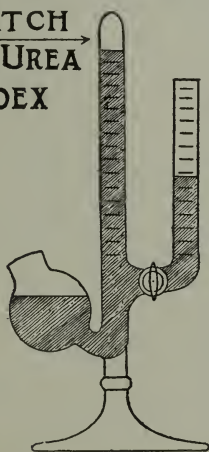
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New York

WATCH
the UREA
INDEX



A SMALL ELIMINATION OF UREA WILL GIVE SYMPTOMS VARYING FROM A SLIGHT HEADACHE TO UREMIC CONVULSIONS

In **BRIGHTS** and other CASES of **NEPHRITIS** the UREA ELIMINATION Can be RAISED, using

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SEND FOR
Samples and
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Case IX. As aggravation of hysterical hypochondriasis of long standing; removed in a few weeks by rational persuasion.

Case X. Phobia in a boy of eight, cured by discipline guided by the data of a rapid psycho-analysis.

In treatment are discarded mystical impression, suggestive and emotional appeal, which are the main reliance of illicit practitioners and too many doctors; so that, as hysteria is the product of an idea, enlightenment by rational persuasion concerning it, combined with motor, sensory and psychic re-education, is the method used to reconstruct the patient's attitude. The therapist must think in terms of dynamogenesis and avoid arbitrary empiricisms.

Finally, clear diagnosis of the mechanism to be overcome is essential, for the physician must not only aim at his object, normality, but must envisage each step of the process required. Nowhere is greater refinement essential.

Editorial Comment.

THE HEALTH CERTIFICATE AND THE RIGHT TO MARRY.

The Journal of the Missouri State Medical Society.

THE organized medical profession of the country has long advocated reforms in many of the practices which an unthinking people have permitted to grow into fixed customs in spite of the knowledge that such customs are detrimental to the health of the community and cursed with a blight that mars the mental and physical perfection of coming generations. One of the most important of these reforms is that of putting a check on the promiscuous marriage of persons who are unfit to assume the responsibilities of parenthood.

A few States have realized the great good that will grow out of proper restriction of the marriage contract and now require certificates of health in both parties before issuing licenses to marry; but the most promising impetus given to this question was the recent announcement of a Chicago clergyman that he would in future wed no couple who did not present a certificate of health from reputable physicians.

The stand thus taken is most commendable. There is great need of some such deterrent to the marriage of persons unfitted by reason of mental and physical imperfections which are transmissible to their progeny. If this requirement becomes a general custom among those authorized to legalize marriage it will pave the way for statutory requirements that will insure to generations yet unborn a right of heritage that is utterly unobtainable otherwise. After that there will be few cases of congenital idiocy, blindness and deformity, for most of them can be absolutely prevented by a precaution of the kind here advocated, and untold suffering will be avoided, to say nothing of the monetary expense spared to society and the State.

The pulpit and the press should sanction and urge a rule of this sort: no measure or custom can be established whose enforcement will operate more radically for the promotion of the health and happiness of the future of the nation. Nor will it fail to

Acute Diarrhea of Infants

MELLIN'S FOOD

4 level tablespoonfuls.

WATER (boiled, then cooled)

16 fluidounces.

Give one to three ounces every hour or two, according to the age of the baby, continuing until stools lessen in number and improve in character. Milk, preferably skimmed, may then be substituted for water—one ounce each day—until regular proportions of milk and water, adapted to the age of the baby are reached.

MELLIN'S FOOD COMPANY

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This diet is especially serviceable for the feeding of infants with diarrhea for the following reasons:—

Readily taken.

Completely utilized.

Protein-sparing, thus preventing tissue waste.

Furnishes sufficient body-heat and energy and supplies enough nitrogenous food to maintain the baby's strength during the critical period.

Maltose, the predominating carbohydrate, has the highest point of assimilation and the lowest degree of fermentation of all sugars.



First, Anatomik Shoes will give perfect comfort from the start and prevent whatever foot trouble may be coming.

Second, Anatomik Shoes almost instantly relieve and permanently correct whatever foot trouble one may have.

Third, that while Anatomik Shoes prevent or correct foot trouble, they are good-looking shoes. They are of the highest quality in workmanship and leather.

Physicians can send their patients to us with the perfect assurance that they will receive prompt attention and that the Scientific Anatomik Shoe will give the foot the support properly required.

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Baltimore's Largest Shoe Store

exert a most needed effect on the present generation in causing the people to have greater care of themselves.

THE SANE CONTROL OF VENEREAL DISEASES.

Long Island Medical Journal.

In a recent bulletin of the Department of Health of the City of New York the opinion is expressed that a comprehensive plan for the sane control of venereal diseases is possible in the near future. As the first step in this direction the Department of Health have secured from the Board of Estimate an appropriation of \$55,000 for a new Venereal Disease Hospital to be situated on North Brother Island.

The resolutions as approved by the Advisory Board and as adopted by the Board of Health in February, require that superintendents or other officers in charge of public institutions, such as dispensaries, clinics, charitable and correctional institutions, including all institutions which are supported in full or in part by voluntary contributions, shall report promptly to the Department of Health the name, sex, age, nationality, race, marital state and address of every patient under observation suffering from venereal diseases. In addition, all physicians are requested to furnish similar information concerning private patients under their care, except that the name and address of the patient need not be reported.

The Board of Health will undertake to make the necessary bacteriological examinations and tests for the diagnosis of these diseases, and the distribution of curative sera, but only on condition that the data required for the registration of the case be furnished by the physician treating the patient.

A copy of the resolutions in full is as follows:

WHEREAS, The venereal diseases are infectious, communicable and preventable, and constitute a serious menace to the public health, thus properly coming under the charge of the public health authorities, and

WHEREAS, It is well established that no administrative control of such diseases is possible without a system of notification and registration, associated with provision for the municipal care of patients unable or unwilling to place themselves under proper medical care and to take the precautions necessary to prevent the infection of others, BE IT THEREFORE

RESOLVED, *First*, That on and after May 1, 1912, the superintendents or other officers in charge of all public institutions such as hospitals, dispensaries, clinics, homes, asylums, charitable and correctional institutions, including all institutions which are supported in whole or in part by voluntary contributions, be required to report promptly the name, sex, age, nationality, race, marital state and address of every patient under observation suffering from syphilis, in every stage, chancroid, or gonorrhoeal infection of every kind (including gonorrhoeal arthritis), stating the name, character, stage and duration of the infection, the date and source of contraction of the infection, if obtainable, and

Second, That all physicians be requested to furnish similar information concerning private patients under their care, excepting that the name and address of the patient need not be reported.

Third, That all information and all reports, in connection with

TO make milk safe and keep it sweet in summer time, add two teaspoonfuls of Dioxogen to each quart. Stir it in thoroughly and allow to stand six hours before using.

To make drinking water safe, add one teaspoonful of Dioxogen to each gallon. Stir it in thoroughly and allow to stand six hours before drinking.

IN BOTH CASES THE
PATHOGENIC ORGANISMS
ARE DESTROYED.

Dioxogen is standardized. Its Carbolic Acid Coefficient is $7 \frac{8}{10}\%$, that is, it is equal in germicidal strength to a $7 \frac{8}{10}\%$ solution of pure (100%) Carbolic Acid. It's harmless, odorless and contains no acetanilid.

THE OAKLAND CHEMICAL CO.
NEW YORK

persons suffering from these diseases, shall be regarded as absolutely confidential, and shall not be accessible by the public, nor shall such records be deemed public records.

Fourth, That the Department of Health shall provide facilities for the free bacteriological examination of discharges for the diagnosis of gonorrhoeal infections, and also shall provide, without charge, vaccines for the treatment of such infections, and

Fifth, That the Department of Health shall undertake to make, without charge, the Wassermann and the Noguchi tests for the diagnosis of syphilis and examine persons for spirochetes.

Sixth, That these diagnostic and therapeutic facilities be extended only when the data required for the registration of the case be furnished by the physician treating the patient, and

Seventh, That the Department provide and distribute circulars of information in relation to these diseases.

This action on the part of the Department of Health is really the first sane attempt that has been made to check the spread of venereal diseases in New York City.

People may be educated and may be made to understand the dangers arising from these diseases, but that will not limit the spread of the disease. The only way to do this is by the proper control of those who have the disease and making it either impossible for them to spread the disease or subject them to punishment upon conviction of the disease having been spread by them. The objection so often raised that physicians could not or would not properly report the existence of venereal diseases is overcome in a measure by the provisions of these resolutions, for it requires that all those who apply to public institutions for their relief must necessarily have their names submitted to the Department of Health and a record of the disease kept in that way. The physicians are encouraged to send a report of their cases to the Health Department and in return the Health Department makes all of the examinations for them and provides them with the means of eradicating the disorder.

The physicians of Long Island are urged to co-operate with the Health Department in this campaign which, if properly conducted, will slowly react to the benefit of the community as a whole.

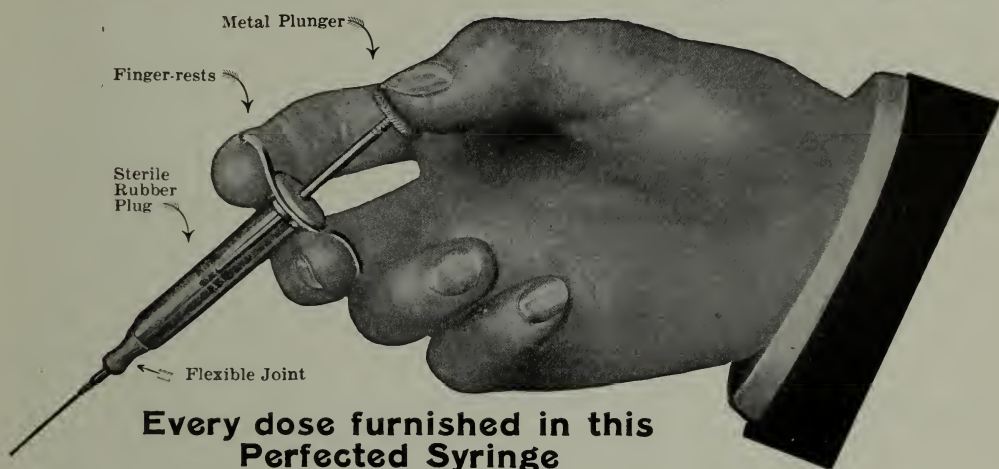
P. M. P.

RECREATIONS OF THE PHYSICIAN.

American Practitioner.

It may be stated with no fear of contradiction that every busy man is the better in mind and body for having a hobby. The fact is too well known to require emphasis, that change is necessary in order to keep the mental and physical machinery in a high state of efficiency. The same kind of work day after day, however engrossing, cannot but become monotonous, and a change of labor and change to some description of amusement at the same time refreshes, stimulates and relaxes the mind and body so that the individual will proceed to his appointed task with renewed vigor. Men of science, those who delve deeply into the secrets of nature, and endeavor to elucidate their obscurity for the good of humanity, especially stand in need of change of pursuit. Happy then is the man who has a hobby outside the routine of his daily toil. It matters not that the task be self-appointed and

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**Every dose furnished in this
Perfected Syringe**

Advantages of New Syringe: ASEPSIS, contamination impossible.

Positive Working: The metal plunger screws into the rubber plug, adjusting pressure and making action positive.

Metal finger-rest with rubber guard at top of syringe prevents any possibility of syringe breaking or injuring operator's hand.

Needle attached with flexible rubber joint permits motion of patient without danger of tearing the skin—a great advantage in administering to children.

Our new adjustable rubber packing possesses great advantages; it is readily sterilized, does not harden, shred, absorb serum or become pulpy.

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beloved, a hobby is valuable. Most of the great ones of the earth have possessed such a means of relieving the strain of continuous and monotonous occupation. Of all men, however, it is most fitting that the physician should be enabled thus to forget for a time his professional duties. It is a question whether relaxation should take the form of an intellectual or physical exercise. This is to a great extent a matter of temperament and constitution, one in which the personal equation plays a great part. Undoubtedly an intellectual hobby is better by far than none at all, and many medical men of past times and of the present day have distinguished themselves in what may not inaptly be classed as unprofessional pursuits. Oliver Wendell Holmes is the most outstanding example in the past in this country and Weir Mitchell at the present time. There can be cited, likewise, the names of many medical men who have gained great fame in spheres of life other than in their chosen calling. This, perhaps, is somewhat of a digression, for many of these may have been cases of the "square peg in the round hole," who did not find their true meter in the practice of medicine.

The point that the writer wishes to insist upon is that the busy medical practitioner is the better for a hobby outside his profession. Although an intellectual hobby is good in that it implies in itself change of occupation and healthy exercise of the brain, an out-of-door hobby is even better, for this implies a certain amount of rest to the mental faculties combined with physical exercise in health-giving surroundings. The busy physician in the city is referred to in particular. In New York, and possibly in a less degree in other American cities, the physician in large practice works as in a treadmill. Except for a yearly vacation he knows no rest, but grinds away all the day and not infrequently a considerable part of the night. The American city physician, unlike his British confrère, does not seem to know how to combine business with pleasure. Most of the London physicians do not work during the whole of the day, but very wisely devote a certain portion of it to amusement. Golf has been a veritable godsend to numerous hard-working medical men in England, for golf is a game that calls for brain power, ingenuity, skill and the exercise of the muscles in a manner suited to a man who is not in the best of training, and above all is played in the healthiest environment. In short, golf provides mental and physical exercise of a high order under the most favorable conditions. There are other outdoor pursuits available to the city physician than golf, although it may be confidently stated that golf is of all best suited to all sorts and conditions of medical men, by reason of the fact that it can be indulged in with equal pleasure by the old and the young, provides gentle or vigorous exercise as the desire may be, and is a healthy stimulus to the mind as well as to the body.

There is no need to labor the point that recreation of some kind is indicated for the busy physician, for he who runs may read. For the country practitioner intellectual recreation will be in place, for the city physician physical recreation, but for both some form of amusement or employment which will for a time take their thoughts away from the work by which they earn their living and which involves responsibility, worry and travail of spirit over those of any other profession or trade.

Sick-Room Linen

can be disinfected and deodorized by placing in a tub half filled with boiling water to which has been added a little "Platt's Chlorides." The tub should then be closely covered for two hours and the clothes thoroughly rinsed before washing.



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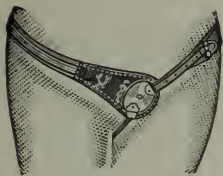
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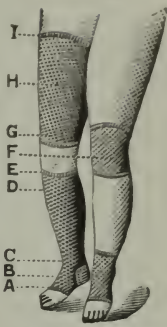
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NATIONAL MEDICAL MEETINGS, 1912

SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	.
Acad. of Ophthal. and Oto-Laryngology.....	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.....	
Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	December, 1912
Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	
Assn. of Medical Examiners.....	G. Strohbach, M.D., Miami Bldg. Cincinnati, O.....	Minneapolis, June 2-3, '13
Assn. of Military Surgeons of the U. S.....	Charles Lynch, Washington, D. C.....	
Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston.....	
Assn. of Railway Surgeons.....	Louis J. Mitchell, 132 N. Wabash Ave., Chicago.....	Chicago, Oct. 16-18, 1912
Assn. for the Stu. of the Feeble-Minded.....	E. C. Rogers, Fairbault, Minn.....	
Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo.....	
Assn. of Official Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.....	
Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.....	
Clinimatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
Dermatological Association.....	James M. F. Winfield, Brooklyn, New York.....	Baltimore, Sept. 12, '12
Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.....	
Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York.....	
Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago.....	
Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York N. Y.....	
Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill.....	
Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	
Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston.....	
Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.....	
Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.....	
Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C.....	
Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
Public Health Association.....	William C. Woodward, Washington, D. C.....	Washington, Sept., 1912
Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass.....	
Surgical Association.....	Robt. G. Le Conte, 1536 Locust St., Philadelphia.....	Montreal, 1912
Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	
Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
Assn. Med. Officers A. and N. of Confederacy.....	A. A. Lyon, M.D., Nashville, Tenn.....	
Balto. & Ohio Assn. of Railway Surgeons.....	T. A. Murphy B. & O. Bldg., Baltimore, Md.....	
British Medical Association.....	Guy Ellison, London, England.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	Washington, Sept., 21-23, '12
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.....	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky.....	Chicago, Oct. 22-24, '12
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	
Nat. Con. State Med. Exam. and Lic. Boards.....	A. W. Sulter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis.....	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.....	
Pan-American Congress, Fifth.....	Dr. Ramon Gutieras.....	
Seaboard Medical Assn. of Va. and N. C.....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.....	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.....	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.....	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo.....	
Western Surgical and Gynecological Assn.....	A. T. Mann, M.D., Minneapolis Minn.....	Cincinnati, 1912

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sandner & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sandner & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Treatment of Gonorrheal Vulvovaginitis in Young Girls.

DR. TIECHE of Zurich (Correspondence Blatt fur Schweizer Aerzte, No. 5) reports the following interesting case: A girl, two years of age, was infected through the mother with exudation for over two months. Treatment commenced December 5, 1910. Daily injection per urethra and vagina of 10 c.c. of ½ per cent. solution of Syrgol. Washed daily with boracic lotion. December 12, 1910, no material change, 1 per cent. solution recommended. December 25 slight watery discharge, no gonococci. Mother is continuing treatment. January 12, 1911, a few leucocytes in mucous, but no discharge. No secretion, no gonococci in slime, February 20, 1911.

I have frequently seen a complete cure in from five to eight weeks by means of ½ to 1 per cent. nitrate of silver, but relapses could not be avoided, although they did not occur in the majority of cases. It has not been demonstrated that relapses will not take place after Arthigen injections.

A case of Vulvovaginitis which came under the writer's notice in 1909 was complicated with rectal gonorrhea in a girl of seven years.

This was a very intractable case with frequent, painful slimy motions, charged with leucocytes and gonococci. Such complications are rare, and it is the first case he had met. Kaumheimer describes a rectal case with these symptoms, which were the prominent features in the above case. It cannot be denied that recurrence may take place from chronic rectal gonorrhea. It is therefore advisable to examine the stools carefully for the slime indications. The action of vaccine on rectal gonorrhea is at present unknown, therefore local treatment with Ichthyol suppositories of Syrgol cones is the safest course to follow. Good results were obtained in female gonorrhea by urethral injections of 1 to 2 per cent. solution of Syrgol and douching with 1 to 3 per cent.; also tampons soaked with $\frac{1}{2}$ per cent. solution. The author, therefore, strongly recommends this preparation of silver in the treatment of vulvovaginitis.

The Ice Bag in Appendicitis.

IN a most interesting article by A. M. Fauntleroy, surgeon, United States Navy, *Medical Record*, August 3, 1912, the fact is brought out, basing the same upon a large number of cases of appendicitis operated, that the ice bag is positively harmful in this condition. In 50 per cent. of the cases operated, where the ice bag was used, the condition seemed to indicate that there was a noticeable lack of effort on the part of nature to wall off from the rest of the abdominal cavity the appendix, which was frequently very much congested, gangrenous or perforated. He also observed that in the ice bag cases there was a surprisingly low white cell count when one took into consideration the condition found in the abdomen at the time of the operation. From 8000 to 11,000 white cells was the rule in these ice bag cases when one would be justified in saying that the pathological condition warranted a constitutional reaction of from 20,000 to 30,000 leucocytes, or even higher.

On the other hand, in those cases in which the hot-water bag or morphine had been used prior to operation (the ice bag not being used at all), the white count corresponded to what one would expect. Dr. Fauntleroy advances from his findings the logic that while the ice bag causes numbness, practically the same as in the condition of frost-bitten ear or toe, it also decreases hyperemia, leucocytosis and stasis in the part to which it is applied. That heat is the direct antithesis of cold in encouraging favorable physiological action in inflam-

A CARD

OUT-OF-TOWN PHYSICIAN, age 30, eight years experience in hospital work and general practice, wishes to become assistant to Baltimore physician. Financial compensation no object. References exchanged. Address

W. W. EICHELBERGER, M. D.,
Glenwood, Md.

matory processes, whether superficial or peritoneal, seems to be from his report most logically and conclusively proven.

In applying heat, whether it be for peritoneal or inflammatory conditions of a more superficial character, the most rational method is to use that which is not only sanitary, but, for the comfort of the patient, does not require frequent changes. In this respect antiphlogistine, on account of its heat retentive properties, its cleanliness and its ease of application, should appeal to the professional mind. That antiphlogistine has proven of great therapeutic value as a thermic agent is best indicated by its extensive professional employment, and its many advantages over the hot-water bottle and other methods of application of heat is readily discernable.

THE steady, increasing demand among all classes of people for Postum as an agreeable, hot table beverage clearly indicates the high estimation in which this wholesome "cereal" coffee is held. The more people come to realize that coffee and tea contain an alkaloid which while useful in the hands of a physician, is harmful in a beverage, the greater will be the call for Postum. This article is made of clean, hard wheat (including the bran coat, with its heavy mineral content) and a small per cent. of molasses. When made right—boiled till rich and dark, as per directions on package—Postum, with good cream, is really a pleasant, wholesome drink.

High-Potency Antitoxin.

A NOTICEABLE preference for concentrated anti-diphtheric serum (globulin), as compared with the older or "regular" form of diphtheria antitoxin, has manifested itself among the medical fraternity. "High potency, small bulk," appears to be the order of the day. A good index to the tendency in this direction may be found in the offerings of the manufacturers, who, as a matter of course, are promptly responsive to each new demand of the profession. For confirmation of the belief that the concen-

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trated product is now in the ascendancy, one has but to turn to the announcement of Parke, Davis & Co. in the current number of this journal, "Antitoxin That Justifies Your Confidence." Here one finds prominently featured the concentrated anti-diphtheric serum (or globulin). It is interesting to note in this connection that a wider range of dosage than formerly is now offered—from 500 to 10,000 antitoxic units—the larger doses, of course, being provided for severe, late or other exceptional cases. And herein, at least, is one undisputed point in favor of the concentrated antitoxin: when a large dose is needed, it can be administered in this form without difficulty and with little danger of disturbance, owing to the comparative smallness of its bulk.

Some physicians, it may be noted, are under a misapprehension as to the nature of the concentrated anti-diphtheric serum (globulin), assuming that it is widely different from the product which they have known for years as anti-diphtheric serum. The idea is wholly erroneous. Concentrated anti-diphtheric serum (globulin) is the regular product, precipitated and purified, from which most of the serum constituents have been eliminated except those bearing the antitoxin. It is in no sense inferior to the original serum—on the contrary,

as previously noted, it possesses the advantage of lesser bulk.

Bacterins.

IN order further to popularize the demand for Bacterins (Bacterial Vaccines), and enable physicians to make more general use of these products, we call attention to the downward revision of prices on Mulford Bacterins, effective August 5.

The Mulford Bacterins are in every case "polyvalent," which means that the bacteria contained in a Bacterin, although of the same species, are obtained from many different sources. For instance, Strepto-Bacterin is polyvalent, the bacteria used for its preparation are all streptococci and are isolated from different patients suffering with streptococcic infections, among which may be mentioned puerperal sepsis, general septicemia, erysipelas, tonsillitis, empyema, cellulitis, etc.

A number of the Mulford Bacterins are "mixed," by which is meant that they contain the various bacterial species generally present in a mixed infection. For instance, the mixed vaccine of chronic gonorrheal infections, besides the gonococcus, contains various staphylococci, colon bacilli streptococci, and other organisms isolated from cases of chronic urethritis and prostatitis.

In some cases diseases from their inception are due to mixed infections, while in many others the infection becomes a mixed one as the disease develops. Past experience and results have fully established the advantages claimed for these "polyvalent" and "mixed Bacterins."

Pollantin Ointment.

THIS new form is added to Dunbar's Serum Treatment for Hay Fever, more especially as an adjunct for the treatment of the nasal symptoms in certain stages of their development, although equally efficient in the eye symptom.

Its rapid absorption by the mucous membrane and ready application commends it highly in any stage of the nasal affection, but particularly so in those cases where the nose has become swollen and blocked by secretion to an extent that neither Pollantin Powder nor Liquid can be applied, or, if so, would and could not be absorbed by the altered mucous membrane, and, again, in cases where either of the older forms may act as an irritant.

The avoidance of the irritating feature is especially appreciable in those cases where even the smallest dose of the powder causes a dis-

treassing attack of sneezing, and likewise in certain cases where the use of the liquid, by reason of carbol-idiosyncrasy, acts as a deterrent, although carbolic acid is present, as a preservative, in but the proportion of one-fourth of 1 per cent.

Pollantin Ointment was but experimentally placed during 1911 with several hundred physicians, and reports received in part from the same as to benefits or otherwise derived from its use give following results:

Benefit, effective, 53 per cent.; benefit, partial, 32 per cent.; benefit, none, 15 per cent.

Your request for general literature pertaining to the Serum Treatment for Hay-Fever will oblige.

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resident in the tissues may be markedly augmented by Cord. Ext. Ol. Morrhuae Compound (Hagee), and with many physicians it is a routine practice to employ it for this purpose. The usefulness of Cord. Ext. Ol. Morrhuae Comp. (Hagee) as a reconstructive lies in the nutritious elements contained, which when fed to impaired tissues build up and strengthen them. Each fluid ounce of the Cordial represents the extract obtainable from one-third fluid ounce of cod liver oil (the fatty portion being eliminated), 6 grains calcium hypophosphite, 3 grains sodium hypophosphite with glycerin and aromatics. It is free from grease and the taste of fish.

Do You Believe the Word of Several Thousand Physicians?

If several thousand doctors told you that in Pasadyne, a distinctive tincture of *passiflora Incarnata*, they had found a most efficient substitute for chloral and the bromides, and that they had given up these latter drugs, would you believe them? While several thousand doctors will never tell you this, yet they could if an opportunity ever presented itself, for it is a fact. Gradually, during the last thirty-eight years, physicians, who have investigated the merits of Pasadyne (Daniel's Concentrated Tincture of *Passiflora Incarnata*), have become users of it in preference to chloral and the bromides, for they have found it to possess just as much therapeutic activity as the drugs named and to be free from their dangerous after-effects. The possibility of habit-formation does not attach to the use of Pasadyne, nor is it depress-

ing. It is the ideal sedative and soporific. A sample bottle will be furnished if application be made to the Laboratory of John B. Daniel, Atlanta, Ga.

As it is generally accepted that milk should not be given during the acute stages of diarrhea, it is necessary to select some diet other than milk that will furnish enough easily assimilated nourishment to carry the baby through the critical period. The form of this nutrition should also be such as to prevent the destruction of the body proteins; otherwise, the baby patient is likely to undergo starvation to such an extent that the chances of recovery are much lessened. A diet of Mellin's Food and water meets these requirements in an effective and satisfactory manner.

Maltose, the predominating carbohydrate in Mellin's Food, is a protein-sparer, and this, together with the amount of soluble proteins and the total food value in the mixture of Mellin's Food and water, is a safeguard against prostration,—so much feared in cases of infantile diarrhea.

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Correspondence.

To the Readers of the Maryland Medical Journal:

About six years ago the writer began to use vaccines in the treatment of typhoid fever. Since that time he has thus treated more than 100 cases, and has obtained numerous articles upon the same subject written by physicians in various parts of the world. It seems possible, however, that some may have escaped notice. He also realizes that many of the profession may have treated some cases without reporting them. A paper upon the subject is now in the course of preparation. In this it is earnestly desired to incorporate reports from a large number of cases—good, bad and otherwise. He accordingly makes the following request to the readers of this JOURNAL:

Will anyone who has used vaccines in the treatment of typhoid fever, whether but one case or more, kindly communicate to him that fact, accompanied by name and address of the reporter? If the results have already been reported, a note of the journal in which they appeared will be sufficient. If they have not been reported, a short blank form will be sent to the physician to be filled out. Due credit will be given in the article to each person making a report. If any physician happens to know of other conferees who have any such cases, it will be appreciated if he sends their names, as they may not happen to read this note. It is hoped that by this means a sufficient number of cases may be collected to somewhat definitely settle the now mooted question whether vaccines are or are not of benefit in typhoid therapy.

Reports of cases will be accepted at any time in the future, but preferably by November or December of the present year.

Kindly communicate with Dr. W. H. Watters, director of the department of pathology and bacteriology, Evans Institute for Clinical Research, Boston, Mass.

Editorial Comment.

THE DUTY OF THE DOCTOR.

The Old Dominion Journal of Medicine and Surgery.

THE last two decades have brought about such advances in medical knowledge (science) that responsibility of physicians is immensely increased. Errors of diagnosis and crude empirical therapy which were excusable a generation ago cannot now be justified, and the practitioner of medicine must bear the responsibility, not merely for what he knows, but for what he may know if he will, and should know if he would make good his claim of fitness to treat the sick. The duty of the modern doctor is twofold:

1. He is morally and ethically bound to make accurate diagnosis. By this we do not mean merely symptomatic diagnosis. Intelligent laymen can do this. But we mean approximately accurate diagnosis of the fundamental or underlying cause of the various manifestations of disease. How often do we hear such diagnosis as "Chronic Gastric Catarrh," "Asthma," "Intestinal Indigestion," "Habitual Constipation," etc. We believe that there is always, or nearly always, a definite pathologic lesion (or more than one) at the bottom of the numerous chronic disorders which are too often described as "functional diseases," and too often treated as such. If the underlying lesion is not discoverable, it



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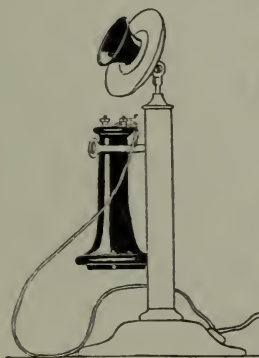
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may be that there is special obscurity in a given case; but as a rule the failure to discover the root of the matter is due either to ignorance or slovenliness on the part of the examiner or to adherence to an antiquated and absolute theory of the cause of disease.

If careful, diligent examination were the rule, and if such examination were conducted always in the light of modern medical science, there would be a wonderful falling off in the number of prescriptions for sedatives, laxatives, tonics and digestive ferments. The up-to-date physician knows that the patient who complains of "chronic indigestion" and "constipation" probably has a chronic appendicitis, with its secondary adhesions; that the victim of frequent headaches has, most likely, an ocular defect; that the "habitually constipated" woman is apt to show a diseased appendix or a retro-displaced uterus, or both. He knows that many a "neurotic" is the subject of hyperthyroidism, and that often a case of "anemia" has been infected with hook-worm.

2. The duty of the doctor who has faithfully endeavored to arrive at a correct diagnosis (and if he is truly in earnest, his effort will usually be crowned with success) is to secure for the patient the best possible treatment. To this all will agree, but as to what is best there is the widest diversity.

The treatment of disease resolves itself into two principal classes—surgical and non-surgical. The classification of "medical" and "surgical" is unscientific and incorrect. All treatment is "medical," for the ultimate purpose of any sort of therapy is to heal, and the words "medical" and "medicine" have their origin in the verb "medico," to heal, and thus properly include all measures which aim at relief of suffering and restoration of function, whether massage, baths, diet or operations.

Formerly the non-surgical cases were believed to be an overwhelming majority of all who apply to our profession for help, but the knowledge is steadily growing upon us that very many instances of disease once regarded and treated as non-surgical are in fact altogether surgical, and not susceptible of permanent relief by any other means.

Mr. B. G. A. Moynihan states that of the thousands which have been referred to him, or have applied to him, for relief from chronic gastro-intestinal disturbances, not merely a part, even a majority, but *all* have proved to be the subjects of surgical disease. The testimony of other surgeons agrees fully with Moynihan's. Necessarily when the general practitioner makes a diagnosis of surgical pathology his patient must be referred to some one else for appropriate treatment, and a word as to the fitness of the referee is not out of place.

No physician is faithful to his duty if he refers his surgical work to half-trained surgeons. The victim of a surgical malady has a right to the best surgical skill, and he trusts his physician to select for him a capable and conscientious surgeon. Unfortunately, the profession is overrun with upstart operators who dare to venture anywhere, yet lack the training, the skill and judgment of first-class surgeons. They are the most dangerous and heartless of adventurers, and their very willingness to undertake the gravest major operations is the best possible proof of their want of fitness.

The duty of the doctor, then, is not fulfilled when he refers his case of appendicitis, cholelithiasis or duodenal ulcers to any man

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who claims to be an operating surgeon. It is an essential part of the physician's obligation to know that his referee has had the training which is fundamental, and that he has the skill which comes only by contact with a number of surgical cases every day.

We conclude, therefore, that the greatest function of the general practitioner in this age is the early recognition of surgical conditions. If he lacks skill in the diagnosis of such diseases, let him acquire it. If he cannot acquire it, he has no rightful place in the profession of medicine.

The reason for our conclusion is evident. The spontaneous tendency of non-surgical maladies is toward recovery. The tendency of surgical pathology is always to grow worse, and finally to reach a stage where hope departs.

Excerpts.

SURGICAL TREATMENT OF HALLUX VALGUS, ASSOCIATED WITH BUNION.

The Journal of the Kansas Medical Society.

THE multiplicity of medical bunion cures constantly exploited and exploded, the application of plaster, pad and iron harness, and their constant failure to ever approach a cure or even give relief from pain, leads me to a belief that the patient suffering from hallux valgus, with its constant companion, the bunion, must look to surgery for whatever of relief he may expect to secure.

The relief of hallux valgus could hardly be classed in surgical significance with work in the abdomen, yet the additional duty imposed on the surgeon of producing a cosmetic as well as a functional result, together with the relief of intense pain, makes the operation one of importance.

The operations suggested for hallux valgus have been many and varied. One, complete resection of the metatarso-phalangeal articulation; operation of Reverdin. Another, resection of the phalangeal articulation and removal of a V-shaped section behind the head of the metatarsus; operation suggested by Kellar. Still another, osteotomy just posterior to the metatarsal head with correction of the deformity; operation suggested by Young.

All of the above have been to a degree successful in the hands of the general surgeon. However, the operation which this paper outlines, and which technique the writer believes has many advantages over those mentioned above, has been credited to Dr. Charles H. Mayo.

A U-shaped incision, base upward, is made on the inner side of the metatarso-phalangeal joint. This incision only through the skin. The skin flap is then dissected free from the underlying bursal tissue. Another curved incision is now made down upon the joint to the periosteum, its base being toward the phalanx, to which it is anatomically so closely attached. This flap is found to be lined with synovial membrane. After uncovering, the metatarsal head of the bone is removed with heavy bone forceps, then smoothed with Rongeur forceps. The bursal flap is now tucked in between the cut surface of the metatarsus and the head of the phalanx, thus placing synovial-lined surface of the flap to the synovial-lined articulating surface of the phalanx. This step insures as a final result a useful movable joint. The flap is held

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in place with two or three catgut sutures. The skin flap is next punctured at its base and a fold of gutta-percha tissue inserted for drainage.

The skin incision is now closed with a lock stitch of catgut or horse hair. A few layers of gauze over the incision and a pad between the great and second toe to insure over-correction constitutes the dressing. Over the entire foot is placed a thin layer of cotton and a light plaster cast, which as soon as dry allows a window to be cut over the site of operation, so that dressings can be easily changed when necessary and drainage removed.

The after-treatment of these cases is simple; ten days to two weeks in bed rids the feet of the swelling incident to the incision. Following this period a week on crutches, with the feet still in the casts, the balance of convalescence in large, easy-fitting shoes, with advice to patient fitting healing of an ordinary bone lesion. Results are uniformly gratifying. Motion is nearly perfect, correction of unsightly deformity, a freedom from pain in walking or standing, and correction of the metatarso-phalangeal ankle, which practically always prevents a recurrence. As the sesamoid bones and cushion beneath are not disturbed, the final result is a bearing surface functionally perfect.—*Dr. J. L. Grove, Newton, Kans.*

THE OPEN TREATMENT OF FRACTURES.

The Journal of the Kansas Medical Society.

THE treatment of fractures is one of the very oldest surgical procedures in the history of medicine.

The advent of a fairly satisfactory bone plate, together with the X-ray work which has been done in the last few years, require a revision of our treatment of fractures.

The X-ray has shown us how very poor our work has been. We have all been surprised at the good functional results often obtained when the X-ray showed how poorly the work was done and how much better work could be done.

The advent of antiseptic surgery made a wonderful difference in the mortality of compound fractures.

Bone surgery is the great field for malpractice suits, and for this, if for no other reason, we should be well prepared to do the best work possible. The people are demanding good results as shown by the X-ray.

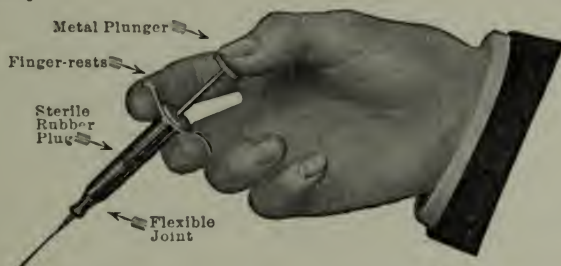
A few years ago Mr. Lane invented a steel plate to be fastened to the ends of the broken bone by screws which has proved very satisfactory. It has been found that the plates must be of the very best and strongest material or they will break. No metal is better than steel. The screws are threaded to the head and must fit the plate. They must be one-half inch or more from the end of the broken bone to avoid the splitting of the bone. Holes must be drilled in the bone, and the drill should be the size of the core of the screw. The plate may be laid over the periosteum, which it does not injure.

The ends of the bones may be turned out; when the ends are in apposition, put back. In compound fractures, instead of scrubbing with soap and water, better results are obtained by using a fresh solution of iodine, one-third the strength of the tincture, or $2\frac{1}{2}$ per cent. This may be used freely in the wound without water.

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Faulty technique is the common cause of failure. The screws will not stay in place if infected.

The X-ray should be used in all cases of suspected fracture when there is any doubt. It should also be used after setting each fracture. Retention splints, like plaster casts, should not be neglected even after using the plates.

Some enthusiastic advocates of Lane's plates have recommended them in all fractures. This is probably going to extremes. Fractures which cannot be properly reduced or easily held in place should be treated by the open method. Cosmetic results weigh little against danger to life. Poor functional results often call for interference. The mortality in fractures, even by conservative methods, is much higher than is usually believed. In non-union, and in some cases of delayed union, the open method of treatment is the best. It is still an open question whether an immediate operation should be performed or wait a few days until swelling has subsided a little and a certain amount of resistance is acquired. There are advantages and disadvantages both ways. Each case should be decided for itself.—*Dr. J. T. Artell, Newton, Kans.*

ANTI-TYPHOID VACCINE.

Colorado Medicine.

THE approach of the "typhoid season" lends special interest to the many observations which have accumulated in the past two years bearing on the prevention by vaccination of this formidable disease. Colorado has in the past borne an unenviable reputation as a typhoid State, and it is to be hoped that the profession throughout the State, as well as the people at large, will be prompt to avail themselves of the new protective agent. It has been abundantly shown that the utmost care on the part of the individual may, and often does, fail in certain circumstances to protect him.

The United States now vaccinates all its soldiers at stated intervals, and the militia of this State is similarly protected. The result has been a most sensational reduction in the typhoid rate and mortality in the army.

The State University announces that it is now prepared to furnish through its department of preventive medicine an anti-typhoid vaccine, prepared from the same stock as that used by the army and according to the army method. This vaccine will be furnished in three sterile glass ampules, containing the three doses needed, to anyone who applies for it for 25 cents, to cover the cost of postage, container, etc. The doses are injected at intervals of 10 days under the skin, but not into the skin or underlying muscle. The reaction is very slight, some local redness and swelling, and occasionally more or less malaise. The protection against the disease appears to be almost as absolute as in the case of smallpox.

The same vaccine can be used as an emulsion for making the Widal test, according to Ficker's method, and, in suitable doses, as a curative agent in the course of the disease itself.

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Experienced physicians find that Ungt. Resinol is almost unailing for the prompt control of itching, whether it arises from eczematous affections, from pruritus ani or vulvae, hemorrhoids, or other source. And, as this letter from Dr. Barber suggests, its continued use may usually be relied on to remove all traces of the trouble of which the itching was a symptom.

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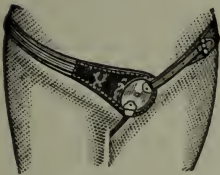
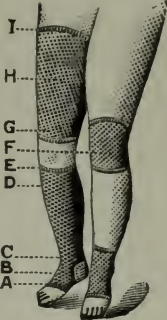
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NATIONAL MEDICAL MEETINGS, 1912		
SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	
" Acad. of Ophthal. and Oto-Laryngology	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	December, 1912
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	Minneapolis, June 2-3, '13
" Assn. of Medical Examiners.....	G. Strohbach, M.D., Miami Bldg. Cincinnati, O.....	
" Assn. of Military Surgeons of the U. S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston.....	
" Assn. of Railway Surgeons.....	Louis J. Mitchell 132 N. Wabash Ave., Chicago	Chicago, Oct. 16-18, 1912
" Assn. for the Stu. of the Feeble-Minded	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave. Buffalo.....	
" Assn. of Official Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York.....	
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York.....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago.....	
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
" Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill.....	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Association.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C.....	
" Proctologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
" Public Health Association.....	William C. Woodward, Washington, D. C.....	
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass.....	
" Surgical Association.....	Robt. G. Le Conte, 1536 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
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British Medical Association.....	Guy Ellison, London, England.....	
Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky.....	Chicago, Oct. 22-24, '12
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Sufter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis.....	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	
Pan-American Congress, Fifth.....	John R. Bagby, Md., Newport News, Va.....	
Seaboard Medical Assn. of Va. and N. C.....	John R. Bagby, Md., Newport News, Va.....	
Southern Medical College Association.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Surgical and Gynecological Assn.....	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.....	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.....	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn.....	A. T. Mann, M.D. Minneapolis Minn.....	Cincinnati, 1912

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Typhoid Fever.

IN a large majority of cases of typhoid fever there is undoubtedly an intestinal lesion, but other organs are also affected. In a few cases post-mortem examination reveals no lesion whatsoever in the alimentary tract. Typhoid fever differs from some of the infectious diseases in that, during its course, the entire body is exposed to a specific bacillus and that the lesions are, therefore, really several fold. Many physicians do not admit this fact, and speak of and treat enteric fever as if it were an infection confined to the intestinal canal. In typhoid fever, on the other hand, the patient may be seriously sick with a non-enteric typhoid and yet have an intestine totally free from the typhoid bacilli and from any of the intestinal lesions of the disease. The report from pathologists show that many cases are now on record in which typhoid fever was present and in which no intestinal lesion was found. If the disease is an infection involving various organs of the economy, the treatment which only has in view the lesions found in the intestinal canal will be inadequate to meet successfully the patient's condition; consequently, a close and careful study should be made of any suggestive cause.

In the treatment of typhoid fever, the patient

should be in an aseptic, well ventilated, light and cheerful room. He should have water at stated intervals. It is a great mistake to neglect this, as when a patient is unconscious he should have water and, of course, does not then ask for it.

The medical treatment of enteric fever is largely symptomatic, the patient suffering from the infection produced by the typhoid bacillus. The body is necessarily affected by splenic toxemia; the intestinal glands and other organs are involved. Prominent among the latter symptoms are emaciation and malnutrition, and this should be combated by a food which will not overtax the digestive system, and will at the same time supply every element of nutrition. Bovinine is ideally indicated as a food. From the onset, antiseptics are indicated and should be administered more or less throughout the entire course of the disease; but, most of all, keep the patient's temperature down by sponge baths, and the strength and nutrition as near normal as possible.

Abdominal Support Without Discomfort.

TO MANY a patient, particularly if nervous and irritable, an abdominal bandage or binder that provides adequate support is a source of extreme discomfort. This refers to the usual binder. But through the use of the Storm Supporter all this annoyance is avoided, since it is so accurately adapted to the anatomy and shape of the mid-region of the body that maximum support is afforded with minimum pressure and constriction. Indeed, the unique feature of the Storm Binder is the frequency with which squeamish and fretful patients refer to the comfort it affords them. "I would never know I was wearing a band, but for the relief I obtain," says one. "The Binder fits and feels so good it seems like part of my wearing apparel," says another. The advantage of all this in caring for obstetric and post-operative cases must be apparent. It goes far to account, moreover, for the remarkable success the Storm Binder has won among surgeons and obstetricians all over the country.—*American Medicine, February, 1912.*

From the University Eye-Clinic at Jena, Prof. D. W. Stock (director), come very excellent reports from Dr. G. A. Hegner, senior clinical assistant, upon the results obtained from the use of Syrgol in conjunctival inflammation, especially gonorrheal conjunctivitis.

The favorable reports of Kollbrunner re-

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OUT-OF-TOWN PHYSICIAN, age 30, eight years experience in hospital work and general practice, wishes to become assistant to Baltimore physician. Financial compensation no object. References exchanged. Address

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garding the use of Syrgol in specific urethritis induced the ophthalmologists at Jena to make experiments with the new preparation. Hegner states that their results have been so gratifying that Syrgol is looked upon by them as a most valuable addition to the various means of treating suppurative diseases of the conjunctiva. He says that, where there is thickening of the eyelid with extreme edematous swelling and the tissues became so hard as to render it difficult to inspect the diseased structures in order to confirm the diagnosis, treatment should be given with the purpose of allaying the inflammation and reducing the swelling of the lid. "Protargol, Sophol and Argyrol have in the past proved beneficial, but since our experience with this new salt, Syrgol, we regard it as superior in its ultimate results."—Hegner.

Syrgol is brownish-black, odorless colloidal oxide of silver. Physically it consists of shining crystalline scales which dissolve in two parts of water. A 5 per cent. solution is almost painless, and does no damage to the cornea.

In 20 cases of gonorrheal conjunctivitis, he reports that gonococci disappeared from the secretions in a short time, and speedy recovery took place in every instance. Three exceptionally severe cases are reported in detail, speedy recovery resulting in each instance. In the three cases described the most noteworthy feature was the rapid disappearance of the gonococci and the prompt subsidence of inflammation.

Good results were also observed in many cases of ophthalmia neonatorum. By using Syrgol healing took place usually in about a week. In two cases recovery took place in four days, and seldom was it necessary to continue treatment longer than two weeks. An interesting fact that he mentions was that two cases which were not doing well previously showed rapid improvement when transferred to the clinic where Syrgol was employed.

Syrgol proved of much service also in cases of conjunctivitis following operation for cataract. Favorable results were obtained also in

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cases of inflammation of the lachrymal ducts. He mentions a patient suffering from an acute dacryocystitis in which there was swelling and considerable redness, together with feeling of pressure over the duct. The sac was washed out thoroughly with a 1 per cent. solution of Syrgol, and complete recovery was obtained in a case where there was a purulent discharge from the lachrymal sac, but no inflammation present. Two such cases, of course, are not sufficient to enable one to draw positive conclusions, but they certainly indicate that good results in both acute and chronic inflammations of the lachrymal sac may be obtained by irrigation with Syrgol.

The manner of applying the remedy is quite simple. In acute cases of blepharitis a 5 per cent. solution is dropped into the conjunctival sac from two to three times a day, and the eye is bathed frequently with a solution of boracic acid in order to wash away accumulated secretions. In some cases it may be found advisable to use a 2 per cent. solution.

The treatment of gonorrheal conjunctivitis is made easy because of the absence of irritation following the use of Syrgol. Instillation of this remedy in the eye and using an antiseptic solution as a wash is quite often sufficient to effect a cure.

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Hay-Fever Hints.

WE are now well into the season when the services of the physician are urgently demanded by the victim of vasomotor rhinitis—a season dreaded not alone by the patient, but, not uncommonly, by his medical adviser as well. Particularly is this true of the latter if he has not kept abreast of the most modern ideas on the therapy of hay fever. In any event, the disease is one that tries the patience and calls for the application of remedial agents that have been proved beyond peradventure.

In the treatment of hay fever the physician rarely has an opportunity for the application of preventive measures. His help is usually sought only after the attack has manifested itself—when the patient is suffering (acutely, in most cases) from the ravages of the disease. Effective treatment is then demanded—and promptly, too. Administration of the supra-renal substance in the form of its isolated active principles, Adrenalin, is undoubtedly the wise procedure at this juncture. One feels safe in saying this in view of the long and effective service which has been rendered by this agent in critical emergencies.

There are a number of forms in which Adrenalin is successfully used in the treatment of hay fever. Adrenalin Chloride Solution and Adrenalin Inhalant come naturally to mind in this connection. The substance is also incor-

porated in the several Anesthone preparations—in Anesthone Cream, Anesthone Inhalant and Anesthone Tape, all worthy of confidence, and especially worthy of trial in cases in which for any reason the older Adrenalin products seem not to be indicated. The Adrenalin and Anesthone products, as is well known, perhaps, to most physicians, are manufactured by Parke, Davis & Co. An exposition of their uses in the malady in question, together with the technique of administration, is now appearing in the commercial pages of the leading medical publications. Practitioners are advised to consult these current announcements.

The Chlorosis of Young Girls.

To permit the blood stream of chlorotic girls to remain in an impoverished state is to expose them to more than one peril. Such patients are usually high-school or seminary girls, struggling with duties that tax their every ounce of force. When the break comes, as it almost inevitably will, the physician has on his hands a girl whose recovery takes much time and care. In most instances this could be avoided were the girl put on Cordial of the Extract of Cod Liver Oil Compound (Hagee).

As a blood-maker and general tissue builder it is of much value in chlorosis. Not only are the blood corpuscular elements increased in number, but also a noticeable improvement takes place in their quality. Cord. Ext. Ol. Morrhuæ Comp. (Hagee) will prove its merit in these cases, and its systematic administration over a considerable period of time will save chlorotic girls much of the distress to which they otherwise would be subjected.

DR. CHARLES P. MILLER of Los Angeles, Cal., thoroughly enjoyed a 6000-mile auto trip through California this summer, because it was his first extended trip without suffering acutely from coryza, caused chiefly by dust.

His immunity this year was due to his use of Nazeptic Wool. He found that by lightly plugging both nostrils with strands of this "wool"—really absorbent cotton suitably impregnated with a properly-balanced medication of menthol, phenol, eucalyptol and methyl-salicylate—just before starting on his day's run, and keeping the plugs in situ all day, he was entirely free from coryza, although ordinarily very susceptible to it.

One of Dr. Miller's patients, a San Francisco

banker, who crosses the bay twice a day, and who formerly had daily attacks of coryza while on the water, adopted the same expedient, and has entirely freed himself of this annoying irritation.

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The American Practitioner.

It is very evident to my mind that rheumatism has finally bowed its head to the inevitable and is to be added to the rapidly-growing list of easily curable diseases.

Since the introduction of antitoxins and the various sera it is no surprise to us to have rheumatism bow its stubborn head and walk under the yoke and do man's bidding. To listen to histories and read reports of how this dreadfully painful, crippling disease has yielded to only a few doses of the latest production of man, known as rheumatism phylacogen, is little short of miraculous—dramatic, to say the least.

The history of phylacogen is not necessary in this paper; suffice it to say that cases numbering more than 100 have been treated, carefully tabulated and watched, and that in 96 per cent. a very rapid disappearance of all rheumatic symptoms have followed.

It is necessary to make a proper diagnosis of your case, eliminating all forms of septic arthritis, especially that of gonorrheal origin. Rheumatism phylacogen may be used as a diagnostic agent, in that if the case is not one of true rheumatism failure will result.

That the case is one of true rheumatism there should be no doubt; then a decision as to how the dose is to be administered, subcutaneously or intravenously, is to be decided. There are advantages and disadvantages in both. There are certain contraindications to the use of the intravenous method. Cases with severe cardiac involvement, with arteriosclerosis and those far advanced, who are near a fatal termination, should positively not receive intravenous medication.

There are no contraindications to the subcutaneous administration. There are, however, some objections or disadvantages in the subcutaneous administration over the intravenous, and *vice versa*; for instance, the subcutaneous administration of either 5 or 10 c. c. wherever placed will produce a swelling and soreness which is at once uncomfortable and objectionable, and should the whole treatment be carried out by this method of administration it would hardly be possible for the patient to rest comfortably upon the bed. The indurations in my experience have been lasting and painful.

The intravenous administration has the advantage in that it does not produce the slightest local disturbance or discomfort when properly executed, and is really no more dreaded by the patient than an ordinary hypodermic. The disadvantages of the intravenous over the subcutaneous method lies in the fact that the systemic effects of the administration are explosive in character and

*Case reported before the Jefferson County Medical Society, May 27, 1912.

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at times violent, as was the case in this one I shall present tonight, and I am inclined to the belief that the more violent the reaction, the more good follows the treatment.

The advantage of the subcutaneous over the intravenous method of administration lies chiefly in the ease and certainty with which the dose may be deposited beneath the skin, whereas the intravenous administration requires some skill besides being purely a surgical procedure. Many operators failing in their first attempts to enter the vein subcutaneously resort to the open incision and subsequently puncture the vein.

It does not occur to me as being advisable or at all necessary ever to give an intravenous injection of anything at any time through an open incision and into a dissected vein with ligatures above and below as was formerly advised. I am in the habit of giving normal salines as well as salvarsan, etc., by the method described above.

Another reason why the intravenous administration by the puncture method should be done, and not by the open incision method, in the treatment of rheumatism is that the dose must be given daily for 6 to 10 days, and if thus given into the vein through an open incision would be prohibitive.

The time allowed for the administration of 10 c. c. should be at least 10 minutes. Rapid intravenous injection of rheumatism phylacogen produces serious circulatory disturbance, blueness of lips, pinched expression, ashy complexion, disturbed heart action, and rapid, shallow respiration.

Within 20 minutes after the injection chilly sensations develop, which rapidly deepen into a marked chill of the chattering variety, which calls for hot-water bottles, extra covers and a complaint of pains in all the rheumatic joints, which by this time are in a state of vibration absolutely beyond the control of the patient. If the dose is the first one, chances are that the reaction will be very severe and the limbs be dancing the Highland Fling, while the victim lies by and takes notice that many joints are cracking and popping at such a rate as to warrant the belief that the final end has come; especially is he convinced when nausea ensues and a hurry call is issued for a pus basin. For 30 minutes the entire attention of the patient, nurse and physician will be consumed in dealing with vomiting and chill, which gradually passes off, when a profuse perspiration ensues, the patient falling asleep. The reaction is startling when one first sees it. We are warned by the manufacturers to give the intravenous medication only after the subcutaneous method fails to cure, or only after testing out the patient on two or three subcutaneous doses, and then to follow with the intravenous in small doses.

Mrs. V. G. Age 27 years. Ill of rheumatism 10 years, commencing in right knee, followed soon in the left. One year ago both shoulders, elbows and wrists, with three fingers and thumb on left hand and thumb only on right hand, became affected. The left wrist became so stiff that motion was almost entirely lost and the motion in all the other affected joints limited to about 50 per cent. of their normal range.

The customary rheumatic treatment was resorted to, in addition

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to five weeks at Hot Springs, Ark.; three months at Martinsville in 1911, and another three months in 1912, and in the interval frequent trips were made to various parts of the country where hopes of relief would be obtained, all to no avail. The only relief obtainable was by free use of aspirin.

For one year she has been obliged to use a cane in walking, and since the arms became involved one year ago has been helpless in so far as dressing, feeding herself, combing her hair, etc., it being impossible to get the hands to the head or mouth.

Admitted to hospital April 24, 1912; walking difficult by aid of cane, both knees firmly bandaged with flannel and very painful; the use of pillows under and between the knees were necessary. Patient unable to move herself in the slightest, the service of a special nurse being needed to make all the necessary movements for the patient, who declared that rheumatism was "a most difficult guest to entertain."

April 24: 10 A. M., 5 c. c. rheumatism phylacogen was administered subcutaneously beneath the left scapula. The only reactionary symptoms were elevation of temperature and pulse which began in three hours and increased until temperature 102° F. and pulse 112 was recorded in eight hours, when both gradually fell to normal. Patient complained of soreness at site of injection, but had a fairly good night.

April 25: 8.45 A. M., 5 c. c. s. q. in right hypogastric region (the back being too sore to admit of further medication). The reaction reached its height within 11 hours, temperature being $101\frac{3}{5}^{\circ}$ F. and pulse 106. Had a good night's sleep, but complained of pain at site of injection (no relief from pain).

April 26: 9.45 A. M., 10 c. c. given in left hypogastric region, and at 10.45 had cold, clammy perspiration with chilly sensation: heat applied. The reaction reached its height in nine hours, temperature being $104\frac{1}{5}^{\circ}$ F., pulse 120. Fairly good night; no relief from pain.

April 27: 9.15 A. M., 10 c. c. given in right hypochondrium region; the reaction reached its height within 10 hours, temperature being $101\frac{4}{5}^{\circ}$ F., pulse 122. Had a fairly good night. No relief from pain.

April 28: 9.15 A. M., 5 c. c. intravenously. Reaction began to show in 20 minutes by marked chill, which was a severe chatter, causing not only the patient to tremble from head to foot, but the bed to be thrown into a state of vibration such as we had never seen. The chill continued for 35 minutes and was accompanied by blueness of lips, ashy hue of face and frequent outbreaks of cries by patient of pains in the affected joints, interspersed with vomiting lasting 20 minutes, projective in character. Reaction reached its height in three and one-half hours, temperature being 106° F., pulse 136, respiration 39, which within 11 hours dropped to temperature $101\frac{4}{5}^{\circ}$ F., pulse 126, respiration 30. Body profusely bathed in perspiration, slept fairly well and awakened free from pain. To our great surprise and delight was able to change her position from side to side at will without the slightest pain, and marked improvement in range of joint action was noted, being

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about 25 per cent. improvement. General condition much improved; patient now able to easily reach the mouth, hair and any portion of the body without pain, and as a demonstration kicked both feet at one time into the air, making flexion and extension without pain; has continued to improve from that day (April 29), notwithstanding the continued rainy weather. The day following the first intravenous injection none was given. Upon this day she was very comfortable and sat up in a chair two hours in the afternoon without pain or discomfort other than stiffness of the joints.

April 30: 9 A. M., 8 c. c. intravenously, followed in 20 minutes by the typical reaction as before described, except not so severe, temperature reaching only 102° F., pulse 120; slept well.

May 1: 8.45 A. M., 10 c. c. intravenously, followed in 20 minutes by typical reaction; temperature $102\frac{3}{5}^{\circ}$ F., pulse 114; slept well and feeling better.

Attention is called to herpes upon right cheek, size of half a dollar, and two points upon back, low down, same size, attributable to phylacogen and approaching menstrual period, which appeared the following day. No phylacogen given during that period; zinc oxide ointment applied locally; herpes disappeared when menstrual period was over. During this rest from treatment patient's appetite improved very much, and she spent most of her days in a wheel chair, with short walks about the hospital, supported by the nurse, going out into the yard when weather conditions were suitable; sleeping better and free from pain.

May 6: 9 A. M., 8 c. c. intravenously, followed promptly by the regular type of reaction, temperature reaching only $103\frac{1}{5}^{\circ}$ F., pulse 130 within 3 hours 45 minutes, but soon receded. Patient feeling better at 2 P. M., sitting up in bed at 6 P. M., enjoyed supper at 9 P. M., and up walking about the room and hall at 9.30 P. M.; retired at 11 P. M. Still complaining of soreness and presenting some discoloration over site of previous subcutaneous injections.

May 7: 9.15 A. M., 10 c. c. intravenously, followed by typical reaction, temperature reaching its highest within three hours, being $103\frac{3}{5}^{\circ}$ F., pulse 124; patient up in chair at 3 P. M.

Dismissed from hospital May 8.

May 9: 9 A. M., 10 c. c. intravenously.

May 10: 9 A. M., 10 c. c. intravenously.

Making a total of nine packages of 10 c. c., each covering a period of 17 days.

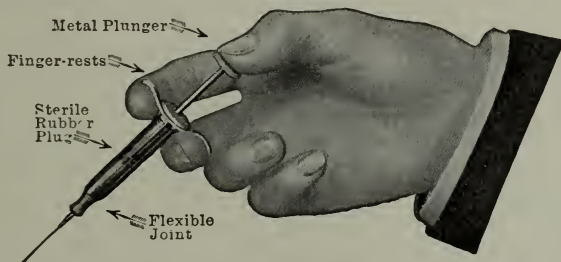
The patient is highly pleased with the outcome of the treatment, and is now, even in this short time, able to sleep better, eat better, walks without pain and unaided, goes every place about the home, dresses herself, combs her hair, and feeds herself and all without the use of aspirin, which she discontinued May 8. Has felt no inclination to resume its use, and has discarded the flannel bandages, while her faithful friend, the cane, has an honored place upon the hall tree.

It is useless to say that so far we are very much pleased with rheumatism phylacogen. It is certainly a boon to this class of

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sufferers, and although the reaction from its intravenous administration is severe, it is to be preferred in suitable cases to the subcutaneous method.

Note the difference in the physical condition in this case report, where subcutaneous injections, even in 10 c. c. doses, did not lessen the painful condition of joints, whereas the very first intravenous, consisting of only 5 c. c., gave immediate relief.—*J. T. Dunn, M.D.*

Editorial Comment.

THE DURATION OF OUR PASSIONS.

Critic and Guide.

LA durée de nos passions ne dépend pas plus de nous que la durée de notre vie—The duration of our passions no more depends upon ourselves than does the duration of our life. So says La Rochefoucauld. But our author is mistaken. For the duration of our lives does, to a great extent, depend upon ourselves. Under strict hygienic living and by avoiding foolhardy dangers we can prolong our life considerably. By excesses, dissipation and carelessness we can shorten it. And so with our passions, by which the author means love. With careful solicitude love can be made to last a lifetime; under brutal manipulation it will soon wither and die. For love is a tender plant requiring loving care.

OSTEOMALACIA, SENILE.

Monthly Cyclopedia and Medical Bulletin.

ATTENTION is called by the author to the fact that, in addition to the common form of osteomalacia related to pregnancy, there exists a variety of the disease occurring in the aged of both sexes, and sometimes mistaken for a process of osteoporosis; six cases of this kind, five in women and one in a man aged 65, are reported by the author. All complained of severe pain in the bones, especially those of the thorax and pelvis; showed a diminution of stature, and had muscular cramps in the limbs when they tried to walk which prevented them from straightening up. The diagnosis from osteoporosis rests upon the fact that in the latter the bone remains hard, losing its strength merely through atrophy and rarefaction of the organic components. Arthritis deformans might also be confused with senile osteomalacia in a superficial examination.

Regarding treatment, the author used with considerable success daily doses of 3 to 5 dessertspoonfuls of a 0.01 per cent. solution of phosphorus in cod liver oil, together with rest in bed and baths as adjuvants. Castration or ovariectomy might also, theoretically speaking, prove of use. *J. Reich (Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie; Revue de thérapeutique médico-chirurgicale, March 15, 1912).*

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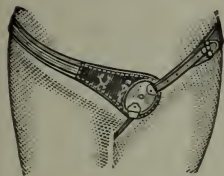
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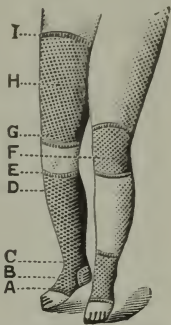
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Seaboard Medical Assn. of Va. and N. C.....	L. C. Morris, M.D., Birmingham, Ala.....	
Southern Medical College Association.....	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Surgical and Gynecological Assn.	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Southern Medical Association.....	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of Md., W. Va. and W. Pa.	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Assn. of Miss., Ark. and Tenn.	Jos. E. Chambers, M.D., 918 Pine St., St. Louis, Mo	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	A. T. Mann, M.D. Minneapolis Minn.....	Cincinnati, 1912
Western Surgical and Gynecological Assn.....		

LOCAL DIRECTORY

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

A New and Promising Agent for the Treatment of Rheumatism.

AN announcement that is certain to cause widespread interest among the profession is being made in a large number of American medical journals in behalf of Rheumatism Phylacogen. The new product is a bacterial derivative originated by Dr. A. F. Schafer of California. The term "Phylacogen" (derived from two Greek words—the equivalent of "a guard" and "to produce") means "phylaxin producer," phylaxin being a name that is applied to a defensive proteid found in animals that have acquired an artificial immunity to a given infectious disease.

Rheumatism Phylacogen (Schafer) is a sterile aqueous solution prepared from a large variety of pathogenic bacteria, such as the several staphylococci, streptococcus pyogenes, bacillus pyocyaneus, diplococcus pneumonia, bacillus typhosus, bacillus coli communis, streptococcus rheumaticus, streptococcus erysipelatis, etc. The basic Phylacogen is a "polyvalent" preparation, since the organisms are obtained from cultures made at frequent intervals and from a variety of sources. To this basic material is added an equal amount of the filtrate obtained by similarly growing and treating the streptococcus rheumaticus of

Poynton and Paine. The product is indicated in all cases of rheumatism, acute and chronic, not due to gonorrheal infection. It is marketed in sealed glass vials of 10 cc. capacity and may be administered subcutaneously or intravenously, the former method being preferred except in cases in which quick results are demanded.

Rheumatism Phylacogen, which is the first of a series of phylacogens originated by Dr. Schafer and about to be offered to the medical profession, has been thoroughly tested clinically in many of the leading hospitals, as well as by competent specialists and other scientific men in various parts of the country, and is said to have shown brilliant results in a large percentage of cases. With the co-operation of Dr. Schafer, and in accordance with his methods, it is prepared by Parke, Davis & Co., in whom are vested the sole rights of manufacture and sale. Physicians who are interested in this new treatment for rheumatism, and every general practitioner ought to be, will do well to get descriptive literature on the subject. It may be obtained by addressing the manufacturers at their principal laboratories in Detroit, Mich. Ask for the "Rheumatism Phylacogen pamphlet" and mention this journal.

Poultices Should Be Sterile.

PROF. GEORGE HOWARD HOXIE of the University of Kansas in his most excellent book on "Symptomatic and Regional Therapeutics" states under the heading of localized inflammation that "the danger of infection should ever be in mind in applying a poultice, for the maceration incident to the poultice favors infection, even if in ordinary circumstances one might consider the area germ proof."

Again he refers under the chapter on Pain to the dangers from using dirty poultices, and that skin affections have been added to the ordinary disorder when bread-and-milk or linseed poultices have been used to relieve pain.

It is thus noted how important, then, it is in the employment of a poultice for the relief of pain and inflammation that a sterile and trustworthy product be applied. Inasmuch as poultices are a means of producing Hyperemia by the use of heat, and in so far as they do this better than by other means, it is interesting to observe that in the belief of Prof. Hoxie that "the clay poultices, known best in the form of

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SINCE the advent of diphtheria antitoxin it is doubtful if any new remedial agent has elicited greater interest than is now being manifested in the bacterial derivatives known as Phylacogens. These products were originated by Dr. A. F. Schafer of California, the method of preparation and technique of application being first presented to the San Joaquin Medical Society in Fresno. To the uninitiated it may be said that the term Phylacogen (pronounced phy-lac-o-gen) means "phylaxin producer," being derived from two Greek words signifying "a guard" and "to produce." The Phylacogens are sterile aqueous solutions of metabolic substances generated by bacteria grown in artificial media. They are produced from a large variety of pathogenic bacteria, such as the several staphylococci, streptococcus pyogenes, bacillus pyocyaneus, diplococcus pneumoniae, bacillus typhosus, bacillus coli communis, streptococcus rheumaticus, streptococcus erysipelatis, etc.

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The Phlacogens are prepared and marketed by Parke, Davis & Co., who have recently issued a 24-page pamphlet which describes them in detail—the process of manufacture, therapeutic indications, dosage, methods of administration—everything, in fact, that needs to be known by the man who desires to use Phylacogens. Every physician in general practice, every practitioner who desires to keep abreast of the latest advances in bacterial therapy, should have a copy of this valuable booklet. Write to Parke, Davis & Co. at their general offices in Detroit, Mich., ask for the "Phylacogen pamphlet," and mention this journal.

Gynecologic Therapeutics.

THE tremendous growth of gynecology in recent years has been confined especially to surgical therapeutics. Even Skene several years ago regretted that medical treatment of female disorders does not receive its merited attention. The practitioner is, therefore, compelled to rely chiefly on remedies which have

been tested by clinicians with years of experience having the best opportunity for observation. The most frequent diseases of women are those that arise from functional disturbances of the pelvic organs. For these we call the attention of the medical profession to Dioiburnia, a combination of vegetable drugs, which has stood the test of many years as an efficient tonic and sedative to the female generative organs.

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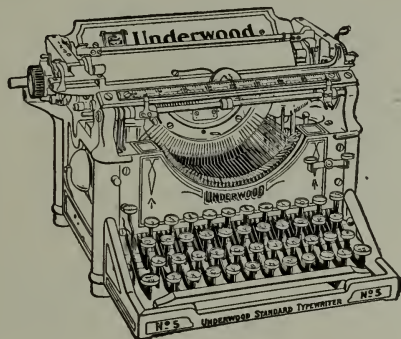
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ARMY MEDICAL CORPS EXAMINATIONS.

THE surgeon-general of the army announces that preliminary examinations for the appointment of first lieutenants in the Army Medical Corps will be held on January 20, 1913, at points to be hereafter designated.

Full information concerning these examinations can be procured upon application to the "Surgeon-General, United States Army, Washington, D. C." The essential requirements to securing an invitation are that the applicant shall be a citizen of the United States, shall be between 22 and 30 years of age, a graduate of a medical school legally authorized to confer the degree of Doctor of Medicine, shall be of good moral character and habits, and shall have had at least one year's hospital training as an interne after graduation. The examinations will be held simultaneously throughout the country at points where boards can be convened. Due consideration will be given to localities from which applications are received in order to lessen the traveling expenses of applicants as much as possible.

The examination in subjects of general education (mathematics, geography, history, general literature and Latin) may be omitted in the case of applicants holding diplomas from reputable literary or scientific colleges, normal schools or high schools, or graduates of medical schools which require an entrance examination satisfactory to the faculty of the Army Medical School.

In order to perfect all necessary arrangements for the examination, applications must be completed and in possession of the adjutant-general at least three weeks before the date of examination. Early attention is therefore enjoined upon all intending applicants. There are at present thirty-five vacancies in the Medical Corps of the Army.

Correspondence.

Editors Maryland Medical Journal:

The following is an abstract of a paper read by Dr. Tom A. Williams of Washington, D. C., in section 4 of the Fifteenth International Congress on Hygiene and Demography, entitled "Occupational 'Neuroses.'" This paper was read on Tuesday morning, September 24:

"Neurosis is a misnomer, for those of occupation are strictly psycho-dynamic inhibitions of disorders in the habitual series of co-ordinated associations gained by education in some art. A want of harmony in the controlling of the mechanism is the fault, and the disharmony is always psychological." This is shown by a series of studies of cases of occupational "neuroses" delineated in detail.

Many cases of various forms of occupational or professional neurosis, including traumatic neurosis of railway and industrial accidents, were described. In these were shown the necessity of addressing the treatment to the psyche, or the mind of the patient. "It is not an incapacity of muscle and nerves to perform their functions, for this is intact except for performing the particular professional acts which fail." Four of the cases described were those of writers' cramp, the commonest occupation "neurosis."

One of the cases described was that of a navy paymaster, who



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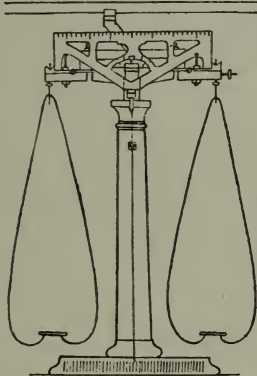
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suffered with writers' cramp, or palsy, to the extent that he was unable, as the day progressed, to write his signature legibly by the time afternoon had arrived. At the patient's first interview with the physician the former was brought to appreciate the psychogenesis, or mental origin, of the trouble. The patient, with this fact clearly in mind, and through his own efforts as directed by the physician, entirely recovered within a month's time. Another case of writers' cramp was shown to have arisen entirely from impatience on the part of a woman of routine letter writing. After a somewhat longer period than in the first case, her writing was practically normal. Two cases of telegraphers' cramp were also described.

The chief difficulty in treatment is to persuade the patient that his disorder is not physical, as he has been told so often. When this is done, graduated exercises accomplish the cure.

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Excerpts.

MEDICINE AS A PROFESSION.

Iowa Medical Journal.

THE young man of today in contemplating a professional career should consider seriously many points before deciding upon medicine. First of all, he should fully realize the enormous amount of work ahead of him. The young man with a strong physical makeup and well-balanced mind possesses a decided advantage over his weaker brother.

One should not arrive at a decision without first making a few observations. A consultation with some of his friends in the profession and a few visits to a hospital where he has the opportunity to see the different types of medical work will enable him to gain some idea of the duties of a physician.

If a young man questions his capacity for work and his ability to sustain the effort, he should not think of entering upon the study of medicine.

The selection of a school is not of as much importance as is generally supposed, so long as one selects one of the standard schools. The didactic work may be secured in any well-conducted medical school. The practical training varies greatly. The smaller schools, properly located, train far better for the profession of medicine than the larger schools which are unable to properly handle the body of students as individuals.

From the time of entering the medical department until he ceases to practice medicine, it is one continuous program of study and work. The physician who permits a year to go by without keeping abreast of the literature of that time cannot compare favorably his knowledge of medicine with the one who has not permitted this lapse of study.

One not in the practice of medicine has but little conception of the amount of original work and scientific investigation being carried on in the many laboratories of the world. The latter term is not restricted to the immense structures which are commonly

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thought of when one speaks of laboratories. Some of the highest types of work are being done under adverse conditions, which only goes to show that individual mind rather than surroundings produces the result.

If one is in love with the study, it is not a labor to carry on the work. No one should consider the profession for a minute who is not thoroughly in harmony with it.

The successes and failures of physicians form an interesting study. Practically every physician should succeed if he is well qualified and has in mind the best interests of his profession. The financial return should be the last consideration. If he has done his work well, the patient is, with few exceptions, pleased to compensate him for his work. If he has treated the patient properly, both in a scientific as well as a personal manner, he need never fear the result. The most scientific and best trained man will not succeed in the practice if he is unfortunate enough to have acquired any habit that makes him disagreeable in the eyes of the patient. He should think enough of himself to care for his personal makeup in a way that is above criticism. Many times he is present in the death chamber where no other than a man of the highest moral type should be. Many men fail because they fail to reach the proper standard of a gentleman. There was a time not many years since when a gentleman with but little knowledge of medicine met with a fair degree of success, but the public today has become more discerning and is seeking the physician who is both well trained and a gentleman—one who must be trusted at all times and under all conditions. One of the first things for the young practitioner to learn is to be able to keep his professional secrets strictly to himself. The law protects him in this. I have known a number of physicians who were greatly handicapped because of their disposition to discuss their patients and their patients' ailments with others.

The practice of medicine has always been regarded as a noble work. To help an afflicted brother is appreciated not only by the brother, but also by those who have an opportunity to observe it. In some countries today the old custom obtains that the physician never makes a regular charge for his services. At certain seasons of the year his patients call and make donations. Considering this, one can readily understand a physician in such a community is not considering the remuneration, but merely that he is doing a good work and will receive his reward not in this world, but in the hereafter. No young man, looking forward to the building up of a fortune, should consider medicine as a career. There are examples here and there of men who have made great financial successes, but the great majority merely secure a comfortable living. Of those who take up the study today, comparatively few drop the work. This is in a great measure due to the fact that the student first considers the requirements for entrance and then the vast amount of work necessary before he secures his license.

It is interesting to consider the position of the physician in the country village. He is always regarded as a man of superior attainments. His educational training should have carried with it the acquirement of a general knowledge which his fellow-citizens



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many times call upon him to exercise. If he is right, intellectually, morally and as a gentleman, his influence in a very large measure directs the destinies of his village. When his life's work is done there is more sincere regret in his departure than in that of the average citizen. He has lived among his people, has helped them in the hour of need, counseled with the leaders of the community and imposed upon no one. There should be none of the ill-feeling that is so apt to be associated with the dealings of the commercial man, following which many times a feeling is engendered never to be forgotten. The work of the physician is always for humanity, and is therefore a noble work.—*Wm. Wilson Pearson, M.D., Des Moines, Iowa, Dean of the College of Medicine, Drake University.*

THE RIGHTS OF A CHILD.*

The Journal of the Kansas Medical Society.

THE State requires of every citizen that he be law-abiding, that he contribute to the general welfare of his community, and that he bear his proportion of the expenses of the government of which he is a part.

In view of these facts every child has, or ought to have, the right to demand of the State the opportunity to grow and develop, both mentally and physically, in a manner that will make it possible to meet the requirements of the State when he shall have arrived at maturity.

The things that determine a child's fitness to fill his niche in the world are largely those forces which surround him after birth. Environment plays so large a part, and hereditary influence during gestation so small a share, in shaping and molding into maturity a human life that it can be left out of consideration.

Certain qualities of mind and heart are the result of inheritance, but they are potential qualities only to be stirred into activity by contact with events and association with other minds.

The physical stature cannot be determined by deliberate intention of the parents, and likewise the mental endowments rests on other than the mental state or activity of the mind of the mother during the period of gestation. The question that concerns us and that particularly concerns the child is what opportunities will be his? Will he be aided to develop normally the highest qualities of body, mind and soul compatible with his natural endowment, or will he be hampered and fenced about with obstacles to such an attainment?

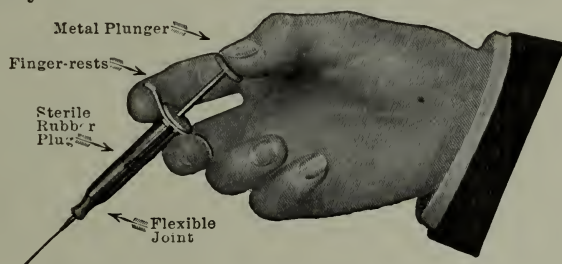
There are nearly 2,000,000 children under 16 years of age who are forced into wage-earning vocations, deprived of their childhood and compelled to labor under conditions that will prevent normal physical growth and that affect the higher functions even more disastrously. No child can stand the nervous strain incident to factory life and come out unharmed. Almost can it be said of children forced to work long hours, particularly in shop and factory, "Who enters here leaves hope behind." A child may be early trained to some useful occupation without injury, but

*Read before the Kansas Medical Society, May 1, 1912.

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he needs time for relaxation, his hours must be short and his task suited to his years.

There are the questions of proper food and clothing, conditions necessary to secure for the child normal rest, the necessity of guarding the child from infections—in short, the general conditions that surround the home life of the child that, if taken up at our instance and discussed with the mother, might do much to re-establish the confidential relation that has been passing with the passing years. People are looking less and less to their physician for help in solving these problems, and yet no other source of information ought to be as reliable or more sought for. Perhaps the more commercial aspect we assume toward our patrons has much to do with the passing of the family doctor.

Then there are the special conditions within the child, faults in his physical make-up, and which, if uncorrected, materially interfere with the child's proper development. Eye-strain is not a myth; the symptoms are well defined and its results far-reaching and often very deleterious to the growing child. Excessive contractions of the ciliary muscles requires extra energy, and often children are unable to expend the extra energy, and organs remote from the eyes suffer as well as general nutrition. Myopia is an acquired defect brought about by excessive use of the eyes. The child may become a myope from eye-strain, or if the structures of the ball do not give way to the continual tug of the ciliary muscle the continued extra energy expended exhausts the individual and he breaks in his school years and manifests numerous neurasthenic symptoms which oftentimes follow him through life and decreases his efficiency in the world. Besides, there is a growing belief that cataract of advanced years is the result of eye-strain in early life. Many children have defective eyes, and eye defects are responsible for their share of physical disability and retarded mental action.

The tonsil has of late years been charged with many crimes against sound physical health. Perhaps in some quarters the indictment is too severe, but no one who has carefully observed children before and after tonsillectomies can doubt the fact that in a considerable degree a true bill is found against the tonsil, and that it must be pronounced guilty of impairing the health and endangering normal development.

One would think enough had been said about adenoids, and yet I think more will be necessary before all awake to the fact that adenoids are always deleterious and often a direct menace to life. Aside from the interference with breathing and the consequent stunted physical and mental development, and the facial deformity occasioned by mouth breathing, adenoids, if not the excitant, are the cause of nearly all middle-ear troubles.

All these physical defects, as well as unfavorable surroundings, do much toward producing the incompetent and vicious. The child has a right to demand a favorable environment and relief from physical defects when relief is possible. The parents are the natural guardians of their children, but it is the duty of the State to hold the guardians to a strict accountability, and if they will not provide the necessary environment and care for their wards, then the State ought to insist that it be done, for it is wrong to allow the children to suffer because of the ignorance or neglect of their parents.—*Dr. J. R. Scott, Newton, Kans.*

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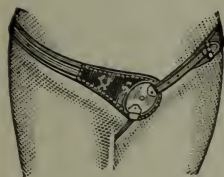
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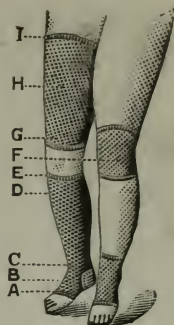
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SOCIETY	SECRETARY	NEXT ANNUAL MEETING
American Academy of Medicine.....	Charles McIntire, 52 N. 4th St., Easton, Pa.....	
" Acad. of Ophthal. and Oto-Laryngology.....	Geo. F. Suker, M.D., 103 State St., Chicago, Ill.	December, 1912
" Anatomists, Association of.....	G. Carl Huber, Ann Arbor, Mich.....	
" Assn. of Genit. Urinary Surgeons.....	E. L. Keyes, Jr., 109 E. 34th St., New York.....	Minneapolis, June 2-3, '1
" Assn. of Medical Examiners.....	G. Strobach, M.D., Miami Bldg. Cincinnati, O.	
" Assn. of Military Surgeons of the U.S.	Charles Lynch, Washington, D. C.....	
" Assn. of Path. and Bacteriologists.....	H. C. Ernst, Harvard Medical School, Boston.....	
" Assn. of Railway Surgeons.....	Louis J. Mitchell 132 N. Wabash Ave., Chicago	
" Assn. for the Stu. of the Feeble-Minded.....	E. C. Rogers, Fairbault, Minn.....	
" Assn. of Obstetricians and Gyn.....	Wm. W. Potter, 238 Delaware Ave., Buffalo.....	
" Assn. of Orificial Surgeons.....	T. E. Costain, M.D., 100 State St., Chicago, Ill.	
" Assn. of American Physicians.....	G. M. Kober, 1819 Q St. N. W., Washington, D. C.	
" Climatological Society.....	Guy Hinsdale, Hot Springs, Va.....	
" Dermatological Association.....	James M. F. Winfield, Brooklyn, New York.....	
" Electro-Therapeutic Association.....	J. W. Travell, 27 E. 11th St., New York.....	
" Gastro-Enterological Association.....	Chas. D. Aaron, 32 W. Adams Ave. Detroit, Mich.	
" Gynecological Society.....	Le Roy Brown, 70 W. 82d St., New York.....	
" Laryn., Rhin. and Otol. Society.....	Thos. J. Harris, 147 E. 40th St., New York.....	
" Laryngological Association.....	J. E. Newcomb, 118 N. 69th St., New York.....	
" Medical Association.....	G. H. Simmons, 103 Dearborn Ave., Chicago.....	
" Medical Editors' Association.....	J. MacDonald, Jr., M.D., New York, N. Y.....	
" Medico-Psychological Association.....	Charles G. Wagner, Binghamton, N. Y.....	
" Medical Colleges, Association of.....	F. C. Zapffe, 1764 Lexington St., Chicago, Ill.....	
" Neurological Association.....	Alfred R. Allen, Philadelphia, Pa.....	
" Ophthalmological Association.....	W. M. Sweet, 1205 Spruce St., Philadelphia.....	
" Orthopedic Association.....	Robert B. Osgood, 372 Marlborough St., Boston	
" Otological Society.....	F. L. Jack, 215 Beacon St., Boston, Mass.....	
" Pediatric Society.....	Samuel S. Adams, 1 Dupont Circle, Wash., D. C.	
" Physio-Therapeutic Association.....	Otto Juettner, M.D., 8 W. 9th St., Cincinnati, O.	
" Physicians, Association of.....	Geo. M. Kober, 1819 Q St., Washington, D. C.....	
" Protologic Society.....	L. H. Adler, Jr., 1610 Arch St., Phila., Pa.....	
" Public Health Association.....	William C. Woodward, Washington, D. C.....	
" Roentgen Ray Society.....	Percy Brown, 155 Newberry St., Boston, Mass.....	
" Surgical Association.....	Robt. G. Le Conte, 1536 Locust St., Philadelphia	Montreal, 1912
" Therapeutic Society.....	Noble P. Barnes, Washington, D. C.....	
" Urological Association.....	Hugh Cabot, 1 Marlborough St., Boston.....	
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Con. of State and Prov. Bds. of N. A.....	H. M. Bracken, St. Paul, Minn.....	
International Congress on Tuberculosis.....	J. S. Fulton, M.D., Colorado Bldg., Wash., D. C.	
Mississippi Valley Medical Association.....	H. E. Tuley, 111 W. Kentucky, Louisville, Ky.....	
Missouri Valley Medical Society of the.....	Chas. Wood Fassett, St. Joseph, Mo.....	
Nat. Con. State Med. Exam. and Lic. Boards	A. W. Suiter, Herkimer, N. Y.....	
Nat. Assn. for Prevention of Tuberculosis.....	Dr. H. B. Jacobs, 11 W. Mt. Vernon Pl., Balto. Md.	
Pan-American Congress, Fifth.....	Dr. Ramon Guiteras.....	
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Southern Surgical and Gynecological Assn.	W. D. Haggard, Nashville Tenn.....	Old Point Comfort, 1912
Southern Medical Association.....	Oscar Dowling, Shreveport, La.....	Jacksonville, Nov. 12-14, '12
Tri-Medical Soc. of Md., W. Va. and W. Pa.	Percival Lantz, Alaska, W. Va.....	
Tri-Medical Soc. of N. C., S. C. and Va.....	J. Howell Way, M.D., Waynesville, N. C.....	
Tri-State Med. Assn. of Miss. Ark. and Tenn.	R. McKinney, Memphis, Tenn.....	
Tri-State Med. Soc. of Iowa, Ill. and Mo.....	Jos. E. Chambers, M.D., 318 Pine St., St. Louis, Mo	
Western Surgical and Gynecological Assn.....	A. T. Mann, M.D. Minneapolis Minn.....	Cincinnati, 1912

LOCAL DIRECTORY

THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

Cardiac Stress—Its Safe and Effective Relief.

OCCASIONS frequently arise when the practitioner must support the heart in order that brief periods of great stress or over-taxation may not result in permanent disability. For instance, during febrile attacks, or at moments of great mental shock, the heart's action is often temporarily embarrassed. At such times a dependable cardiac tonic is needed, and for a good many years cactina pillets have been employed by thousands of physicians with the utmost satisfaction.

This carefully prepared preparation of cereus grandiflorus has been found to give the tired heart the exact support and bracing effect required to enable it to meet safely and without discomfort sudden and unexpected drafts on its functional capacity. In the presence of cardiac palpitation, irregular action, tachycardia or the various other symptoms pointing to fatigue and functional weakness of the heart, cactina pillets afford prompt relief and rapidly remove the patient's apprehension and fear. Indeed, it is not unusual for a patient to run the whole gamut of the customary heart remedies without the slightest benefit until he is placed on cactina pillets. There can be no question that this remedy is especially effective in the cardiac neu-

roses, and it has the great advantage that it can be used without a single fear of any idiosyncratic or untoward effect, or cumulative action, no matter how long or continuously it may be administered.

The practitioner who familiarizes himself with the virtues of cactina will be gratified to learn the extent to which he can rely on this valuable remedy as a heart regulator and support. And the more he uses it the more he will see that cactina is not a spur or a goad—but a thoroughly dependable tonic and prop.

Postum.

THE doctor in his unselfish work for others often fails to apply for his own benefit the valuable knowledge he continually renders, in service, to his patients.

Caffeine—the drug in coffee and tea—is as harmful to the doctor himself as to others.

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Intestinal Torpor.

FEW ailments coming within the daily notice of medical men are more difficult to correct than the constipation that afflicts those of sedentary or lethargic habits. These patients are usually heavy eaters and engaged in pursuits that too often require excessive mental effort and a minimum of physical exercise. While at first little or no discomfort may be felt, as time goes on the depressing influence on all physiologic processes produces more or

less derangement of the metabolism, and faulty elimination dams back into the system poisons that work still greater mischief. Soon these patients become confirmed “toxemics” from the constant auto-intoxication that results, from the retention of perverted and waste products. All manner of symptoms appear, the nervous system particularly showing the greatest variety ranging from simple neurasthenia to the gravest types of melancholia. Indeed, the opinion is growing that defective elimination of bodily wastes is one of the most important factors in the development of many of the mental, as well as nervous disorders, that are apparently on the increase.

The great importance, therefore, of preventing waste accumulation by clearing out the avenues of elimination cannot be overestimated.

Among the means that scientific study and research have brought forward for bowel elimination, Prunoids certainly hold a unique place. This remedy presents advantages that will appeal at once to both patient and physician. Although exceedingly active, Prunoids never set up undue peristalsis; nor do they ever exert a harsh drastic action on the intestinal mucous membrane. Griping, pain and discomfort are conspicuous by their absence, and the effects produced are mild, pleasant but very complete and satisfying. In fact, no other cathartic or purgative at the command of the profession produces more complete and perfect evacuation of the bowels with less discomfort and distress. The reason for this is evident as the action of Prunoids is studied. Their whole influence is physiological, that is they act by increasing and promoting natural processes, never by supplanting them. With this so true, it is not surprising that Prunoids never give rise to reactionary constipation, as is the case with most other laxative remedies. Used properly for a reasonable period, Prunoids may be relied upon to restore the bowel functions, overcome constipation and afford pronounced relief from intestinal auto-toxemia.

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received from leaders in the world's thought, action and culture.

Bronchitis.

THIS disease, which usually results from exposure to dampness or severe dry cold, is a most common one, and in no small percentage of cases it is sufficient to cause disastrous results.

In the first or acute stage, there is always considerable congestion, followed by inflammation of the mucous lining of the bronchial tubes. The patient experiences much pain and coughs frequently. There is usually a harsh sound to the breathing and a fever of high degree.

Pain attending the act of breathing tends to make the patient more or less irritable, and there is a consequent loss of strength. The appetite may also be lost.

If the patient is immediately placed upon Glyco-Heroin (Smith), relief will soon follow and the attack brought to a happy termination.

When the disease has advanced to the second stage, the secretion from the bronchial mucous membrane becomes viscid, ropy and profuse—so much so, in fact, that breathing is exceedingly difficult and painful, and the patient experiences considerable loss of strength.

In both acute and chronic bronchitis, Glyco-Heroin (Smith) produces splendid results. The patient is relieved of cough, fever, difficult breathing and nervousness; sleep is made healthful; strength is preserved and appetite restored. Meanwhile, the inflammation of the breathing passages is subdued and repair of the affected parts begins.

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THERE never was a time when so much thought was devoted to the prevention of disease as now. Modern science has shown that true prophylaxis starts with the individual. It is, accordingly, the age of personal hygiene, not the least important detail of which is mouth disinfection.

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AND a most agreeable one, too, if you have been using chloral and the bromides wherever you wanted to quiet a restless patient or overcome insomnia. The surprise will come when you begin using PASADYNE (Daniel's Concentrated Tincture of Passiflora Incarnata) and find how much more efficient it is than chloral and the bromides, and how free from their dangers and untoward effects. The next time you want to sedate a patient, use PASADYNE and experience the surprise spoken of. A sample bottle will be furnished if application be made to the Laboratory of John B. Daniel, Atlanta, Ga.

Atophan Is Rapidly Gaining Ground— Novatophan, the Tasteless Atophan.

Soon after the discovery of the remarkable uric acid-mobilizing, analgesic and antipyretic properties of the two-phenylquinolin, four-

carboxylic acid (Atophan) and its derivatives, the prediction was made that Nicolaier's researches in this field would ultimately prove as great a boon to modern therapeutics as those which led up to the introduction of Urotropin by this eminent pharmacologist. Though barely 18 months on the market, the preparation bids fair to fully realize these ambitious expectations.

The extensive pharmacologic and clinical studies to which Atophan has been submitted during this period, both by American and foreign investigators, have definitely demonstrated that it stimulates the uric acid excretion to a degree never before attained, and possesses the ability to mobilize it from the blood and the tissues to counteract its abnormal retention there; in brief, to regulate the uric acid metabolism selectively. Its superiority over the colchicum preparations and the salicylates lies in the far more reliable and prompt relief it affords from pain and inflammatory symptoms, and in the entire absence of depressant and constipating by-effects of strong diaphoresis. The striking palliation, shortening or entire suppression of the attack under Atophan therapy, the rapid absorption of joint effusions and in many cases even the disappearance of the tophi, have gained for this preparation prompt recognition as the foremost remedy in acute gout.

In the chronic forms of gout, its employment during attack-free periods as a prophylactic to reduce the frequency and intensity of the attacks is proving of inestimable value. In articular rheumatism, too, and in a great many other painful inflammatory conditions in which perverted uric acid metabolism is frequently a contributory cause, Atophan is rapidly becoming the preferred constitutional medicinal treatment, such as in gonorrheal arthritis, neuritis, sciatica, neuralgia, lumbago, hemicrania, migraine, the non-specific types of iritis, episcleritis and otosclerosis; in eczema, pruritus, urticaria and other skin diseases pointing to excessive acidity of the blood; also in pyorrhea alveolaris, looseness of the teeth, erosions of the anamel, etc.

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